THE JOURNAL
OF THE
Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 37 JULY, 1938 No. 7

THE DOCTOR AND A SCHOOL HEALTH PROGRAM*

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When one gives thought and consideration to the problems of health he must necessarily take into consideration the fact that a health problem of a community is one of the many problems that exist in that community. There is first, the need of supplying the very essential needs such as food, clothing and shelter. Next comes the problem of health and education. It is generally considered that education comes ahead of health since education is a means both to existence and to health. The need of first essentials of existence is always recognized. Education is very popular with the parents and with the large percentage of our population. The health needs of our people are approached in a different manner by different groups of our population. All of us want health, but many of us do not know how to obtain it, and if we know how to obtain it are not willing to make the effort or pay the price to obtain it. Some probably are not able to pay the price, and others do not know how to or where to obtain it.

There never was a time when there was so great a general interest in the health of our people as now. There have been various foundations and philanthropists, also various voluntary health agencies, that have from time to time interested themselves in the problems of health. At present, various magazine writers are contributing articles upon health and means of providing it. All too frequently, these individuals are not willing to approach the problem fairly and honestly, giving all sides to the question, but seem to feel that they must further propaganda either to satisfy their own ego or to furnish something to magazines catchy enough to interest the reader. Fortunately, there seems to be a tendency more and more, to realize and furnish the facts. Many of these voluntary agencies also had preconceived ideas as to the manner of approach to the problem and its solution. Their motive was good; some good results were obtained, but the benefits have not always justified the effort. There is no question that they have increased the interest, which was a wholesome result. The need of greater attention to health has been generally recognized by the medical profession, contrary to the opinion of many. These needs have often been called to the attention of the public by the medical profession. It is my opinion that a great deal of the effort which might have been put forth by the medical profession in coöperation with these agencies was not exerted because of recognition by the medical profession of the futility of such procedures, and because of the fact that these organizations were not open-minded enough to work out a coöperative plan. In support of the contention that this procedure is necessary, I wish to call to your attention the work of the Kellogg Foundation, the Detroit Board of Health and the

*Presented by Dr. Cook, President of the Michigan State Medical Society, before a School Health Educational group May 27, 1938.

Childrens' Fund of Michigan. These foundations have to a more or less degree formulated their plans in conjunction with organized medicine, either state or local.

I would like to make the point at this time that one of the greatest barriers to the support by the medical profession of many health programs is the lack of understanding of the medical ethics. It must be recognized that the principle of not interfering between the patient and his physician must be held inviolate if the best results are to be obtained and if coöperation of the medical profession is to be given. The medical profession has always been willing to give its aid and its advice in medical problems which have to do with health, whenever it has been honestly sought and this principle recognized. I believe, in fact I am certain, that most of the larger organizations successfully dealing with health today, recognize this ethical need and are strictly adhering to it.

There is no question that our health organizations, including state and local, have contributed greatly to the health of our communities, and when I speak of local agencies I wish especially to call attention to the school health programs of the various communities. I believe that it goes without saying that all of our agencies outside of the medical profession, which are really active in the work, recognize the need of a better correlation of the activities of all individuals and organizations which have to do with the problem of health. This is especially true in the health work in our schools because school health work is a major part of, but still a part of the general health program of a community, and while this is true it needs special attention under the guidance of some one especially trained in school health work.

Let us consider the various individuals who have to do with the establishment of and effectively carrying on a good school health program. We have first, your school administrative staff, your school board to whom the administrative force is responsible and who must see that funds are supplied to carry on the work. You have also the principals of the various schools, the class room teachers and your physical education teachers. Then you have the parents whose cooperation is so essential, as well as the doctor who must coöperate with the schools in the work outside of the school. If the funds are to be provided, your Board of Education and your administrative staff must be sympathetic to this health work. Your administrative staff and your school physician, who is so important, and his staff of nurses, your teaching staff, your physicians who are members of the school staff, must recognize the essential things in the work of the program and must, at all times, recognize what their own part is in the program, as well as the rights and duties of the other individuals or groups, and must, at all times, respect and recognize the position of each other. If they do not respect the relationships of each other, confidence is destroyed, and cooperation is entirely dependent upon confidence.

Let me quote Surgeon-General Thomas J. Parran: "Most of the complications which have disturbed the relationship between public health workers and private practitioners of medicine are unnecessary. In some cases highly competent physicians have failed to take the requisite interest in proven public health methods. On the other hand, many able public health administrators have lost touch with the clinical viewpoint and personal problems of the private practitioner. Lack of understanding is bound to breed clashes between two groups who are necessarily in close contact in their daily work. Knowledge and freedom from prejudice are indispensable to the solution of scientific problems. They are no less necessary to the establishment of a harmonious relationship between public health work and private medical practice, which are the two useful arms of the greatest of sciences."

Let me also quote our State Health Commissioner, Dr. Don W. Gudakunst: "A careful analysis of the situation reveals that the school health programs have been very ineffectual." He points out the need of the physician being made an integral part of the school health program. He also states that coöperation and assistance from any group of individuals, be they physicians or others, need not be expected unless they are fully aware of the procedures and play some part in every step. He states further: "Most of the efforts have been directed to sending children to physicians without adequate thought to the preparation of the physician to meet the special problem. The physician then needs special training in this work."

I believe that a careful analysis will show that in our school health work over the past

two decades we have set out upon a campaign of finding defects and their correction, also carrying on a campaign of immunization and disease prevention, certain education as to diet and care of the body, and finding that each year following we had the same number of defects to correct and the same problems existed as did the previous year.

We have, through this system of correction of defects in the school, taught the child and the parent not to correct a defect himself but to look to the school for this service, when, after all, a school is an educational institution. It is far more important to teach an individual to look after himself than it is to teach him to be a dependent. We must also recognize that our dependency is increasing to such an extent that the time will come when we will not be able to meet the problems if we have not already come to that time.

Keeping in mind the points which I have tried to make previously, and having the funds available in the development of school health programs, we take into consideration those who have part in the work. We have first, a school physician who has entered the field of school health work for various reasons. First, he may be a young man who has just served his interneship, but for economic reasons he may feel that a job with a salary gives him more assurance of security. He may be an older man who has not done well in private practice, or he may be a man of good training with proper experience in the work. His attitude may be that education in health is of prime importance, or he may feel that it is the job of his department to correct defects. The attitude of the school physician will be reflected in the whole program, in the work of his whole staff and in the work of all people in the schools who have a part in the program. If his prime interest is in health education. education will be the prime motive, or if he has not the viewpoint of the need of health education the program of all in the schools will be towards the correction of defects and health education will take a minor rôle. On the other hand, in my opinion, if he is interested in health education and in teaching the child and the parent what needs to be done and how to obtain it through health education, many of these people will take care of themselves, saving the school funds for a broader program of health education.

I do not wish it to be understood that I feel any child who needs medical care and is unable to obtain it, should not be cared for. I shall later, point out the way in which that should be handled.

This school physician will have, at his hand, a group of nurses employed to do school health work with various trainings and backing of experience. Some will have one viewpoint and some will have another. Some will understand the motives of the program and plans, some will be sympathetic to it; all of these nurses must be molded into an organization willing to give their best efforts because they believe in the program. On the other hand, you have a group of school teachers, class room and physical education teachers. The class room teacher has had very little training in health work. She will be sympathetic to any reasonable program and will usually follow the leadership of the school physician and the school nurse if the teacher thinks it is a worthwhile program. It must be sold to them. The teacher is the one who probably has the least formed opinion. Then, we consider the group of physical education teachers who have received certain information as regards health from various sources and colleges, no two of whom have the same ideas, each teacher having to a degree an opinion of his own. They are sympathetic to health work, in fact, they are much more enthusiastic than the ordinary class room teacher since they have had more interest in health work. However, the opinion of all these people must be molded into the program.

Then, on the other hand, you have the private doctors, many of whom are practicing individualistic medicine, who have not learned to think in terms of group practice and are not experienced in collective thinking, who sometimes have had unfortunate experiences with certain public health officials who did not recognize the problem of the private physician and who probably feel that the private doctor is critical of them. Fortunately, this is not always true. There are many physicians who are studying and thinking today in terms of the health interests and health welfare of the community and are willing to lend support to any group or groups of individuals who are hon-

est in their efforts to solve these problems. They, however, will not have confidence, let me repeat, in any group of health officials who do not recognize the relationship of a doctor to his patient. It is not financial, but it is relationship which a doctor prizes highly and wishes no one to interfere with it. Possibly, many may feel that this is an unreasonable position—the doctor does not think so.

I have endeavored to point out to you the idiosyncracies of these various groups which we have to deal with, but it is necessary that we recognize these idiosyncrasies in the working out of a health program, and if any health program is to be worked out and it is to receive the coöperation of any one of these groups, it must be worked out by them through joint effort and cooperation. This has its advantages, first, because each one will then understand what the program is and what they are trying to accomplish. It is his baby and every father loves his own child. Then, and only then, can you expect the support of each group. All the differences of opinion must have been ironed out in advance in so far as possible. There will be enough which will arise afterwards.

It is probable that in the working out of a program it is better to have the medical profession represented by a committee especially interested in and sympathetic to the school health program. After this program is worked out and approved by all, then it will be the job of the committee of which the school physician is a member, to explain and sell it to the medical profession in that community. If this is done properly, a certain per centage of the physicians in that community will be perfectly willing and anxious to coöperate. However, we must keep in mind the background of what has transpired in the relationships between the medical profession, the dental profession and our school organization in the past. There may be certain prejudices and certain misunderstandings that still need to be wiped out. Then again there may have been a good understanding and good working arrangements before, and it would then be easier to effect the program.

This advisory committee to the school physician has two advantages and should be continuous. In the first place, it is the approach to the medical profession of the community and should be able to iron out many of the difficulties before they occur. Secondly, it should be a very helpful medium in getting across to the medical profession of the community what the problem really is and what the schools are trying to do to educate the parent and the child in health. They would also become familiar with the work that needed to be done with the child of pre-school age. As a result of this, plans could be made by this advisory committee to develop the interest of the medical profession in these problems of educating the parent in the needs of the child of pre-school age. If the physicians of the community become interested in these problems of preventive medicine and sometimes curative medicine, and the parent and physician coöperate in meeting these problems, much of the work of the child in the school will have been taken care of and the problems of the school will be reduced. Greater effort then can be exerted in health education in the school.

You may wonder what some of these problems are. O'Neill and McCormick of New York report that 43 per cent of school children show evidence of over fatigue; 70 per cent eat not more than one egg a week; 18 per cent eat no fruit; 74 per cent of older children eat candy excessively at home and between meals; two-thirds of children commonly use laxatives; 35 per cent of all and 70 per cent of older children attend movies once a week; 27 per cent have mental maladjustments. In New York, five thousand people develop need for mental hospital every two years.

In addition to these problems of the child which the physician should understand in order to properly advise the patient, there is the problem of immunization early in life before the child attains school age, the correction of the defects found, and frequent physical examinations of the child by its own doctor. If the physician does this work he will have relieved the load of the school health department greatly, the work to be carried on in the future will be less, and the work with the child in school will be much easier since the parent will understand what it is all about.

A very admirable method of broadening the experience, understanding and sympathy of school work was developed in the city of Detroit where certain young physicians were employed one day a week in connection with the school health program.

Their employment only continued for two years, one-half of them leaving each year. In this way there was constantly a new group of physicians becoming familiar with school work and also a group going out into private practice or continuing in private practice with a much better understanding of school work.

There will, of course, be many medical problems which will come up with the child in school, who then may be referred to its own doctor, the doctor knowing what is expected of him.

One of the criticisms which may be made of this outline for a program will be that no provision is made for the care of and correction of defects in the child who is unable to pay for it. It is my opinion that it is the business of the school organization to educate the child in health matters and to find potential defects but not to make a diagnosis or to correct the defects. It is the business, however, of the schools to see that these people get into the proper channels for their examination, diagnosis and correction. If, as a result of the program worked out, it is found there are any number of children in school who are not having their defects corrected or unable to get the medical care required, it is the business of the medical profession in that community to develop proper plans to see that the proper care is available.

I have purposely avoided development of a definite school health program to meet the needs of the schools, but have endeavored rather to point out the way to develop the machinery for the formation of plans and programs and to point out means of perfecting the organization which will be charged with the development of plans and obtaining the results.

In conclusion, it is my opinion that the proper school program, or any other health program, requires the confidence and cooperation between all parties concerned with it. There should be no disagreements between the medical profession and the school health authorities. There must be a thorough knowledge by all concerned as to what the aims of the program are and every fair effort must be put forward to place the program foremost in the objective, and the whole program must be carried on, on a strictly ethical basis.

THE VENEREAL DISEASE PROBLEM, ITS PREVENTION AND CONTROL IN INGHAM COUNTY, MICHIGAN*

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Several years before the awakening of the Nation to syphilis as a major health problem, a group of private physicians in Ingham County, Cichigan, had sought to arouse interest in the prevention tnd control of this disease in their own community. A public health committee had been appointed which secured from the entire membership of the Ingham County Society information on the individual physician's interest in venereal diseases, his willingness to treat syphilis and gonorrhea, and the success of his efforts in detecting the infection in its early stages.

Armed with these basic facts, the Public Health Committee requested the Surgeon General of the United States Public Health Service to coöperate with them in establishing the prevalence and incidence of these diseases in Ingham County and in evaluating existing facilities for their prevention, detection, and treatment.

Part I of this report makes available these factual data on the syphilis and gonor-

*The final meeting for the year of the Ingham County Medical Society took place in May. The event was a symposium based on an exhaustive study of the syphilis problem in Ingham County. Three papers were presented which are here published. The first embodies a study by Dr. A. J. Aselmeyer, Surgeon of the United States Public Health Service; the second, a paper by Dr. H. L. Keim of Detroit, on the application of the survey to the private practitioner; and the third, a paper by R. S. Breakey of Lansing, on the program for control of genito-infectious diseases in Ingham County. As a prelude to the meeting, short discussions were made by Dr. Henry Cook, president of the Michigan State Medical Society, Dr. Loren Shafer, chairman of the State Committee on Syphilis Control, and Dr. Don W. Gudakunst, Commissioner of Health for the State of Michigan. This number of THE JOURNAL contains a paper by Dr. Harold R. Roehm of Oakland County Medical Society on the survey of syphilis in Oakland County for 1937. —EDITOR.

rhea problem in Ingham County and appraises the existing detection, prevention, and treatment facilities.

Part II of this report presents a program

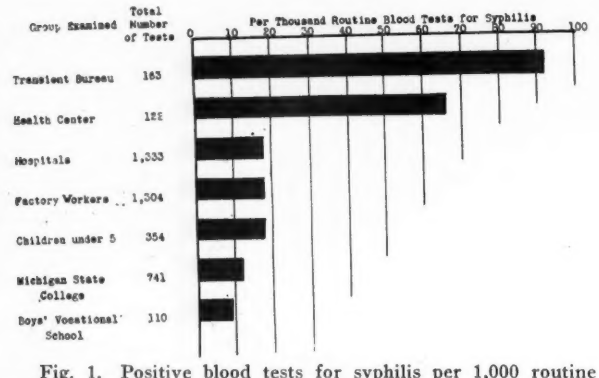


Fig. 1. Positive blood tests for syphilis per 1,000 routine examinations of the blood during a sixty day period, Ingham County, Michigan.

for the control of venereal disease. This program is submitted by the Public Health Committee to the Ingham County Medical Society for consideration and recommendations. It was designed to secure for the public, adequate protection against the spread of venereal disease by infected individuals and for the individual patient, adequate treatment, skilled medical care, and maximum privacy.

PART I

Methods Employed in the Survey

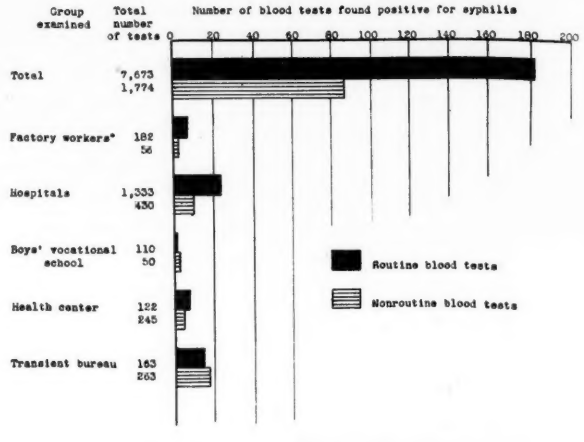
Two methods were proposed for establishing the extent of the venereal disease problem.

1. A novel plan, that of a routine blood test on all patients coming under the care of each private physician in active practice in Ingham County during a sixty-day period (January 15 to March 15, 1938).
2. A census of cases of venereal disease actually under treatment or observation by any authorized source of treatment within a given period (September 15, 1937, to January 15, 1938, for syphilis) and (December 15, 1937, to January 15, 1938, for gonorrhea).

The use of these two methods offers an opportunity to establish the ratio of under-treatment infected individuals to the potential treatment load.

1. *Routine blood tests.*—

The plan of making routine blood tests on all private patients within a given period met with the approval of the entire membership of the Ingham County Medical Society. Splendid coöperation was obtained. Some 7,600 bloods were examined in a period of two months, as compared with 1,770 in the preceding two months. Two hundred thirty-six additional individuals with syphilis were discovered. Routine blood testing became a reality. Courage was essential to put into action such a procedure.



* Omitting Reo Plant, in which no tests were made before survey

Fig. 2. Absolute number of blood tests found positive on routine examination of certain groups compared with results from nonroutine blood tests.

Previously, blood tests had been made only on private patients for diagnostic or treatment control purposes. No one knew how much syphilis was hidden. Early in the operation of the plan the physician learned that the average American citizen offered no objection to the examination of his blood. These pioneers have led the way to the most effective present-day method of uncovering hidden sources of infection.

The number of individuals actually under treatment or observation for syphilis represented only one-sixth of the potential treatment load for the disease as detected through the serologic survey.

In Figure 1 is shown the rate of positives per 1,000 bloods tested in various groups of individuals. The amazingly high rate of positive bloods among individuals in transient camps lends some credence to the often repeated statement that much of the syphilis in our community is brought in from neighboring states; that to be won, the syphilis war must be waged on "forty-eight state fronts." In practically every group tested, at least one out of a hundred had evidence of syphilis.

The effectiveness of the routine blood test in detecting syphilis is apparent from a comparison of those uncovered in the present survey period with those found prior to the survey. Figure 2 makes an eloquent plea for the continuation of routine blood testing for syphilis.

Since the average number of patients seen by each private physician was unknown to the investigators, it was necessary to show the absolute number of persons examined

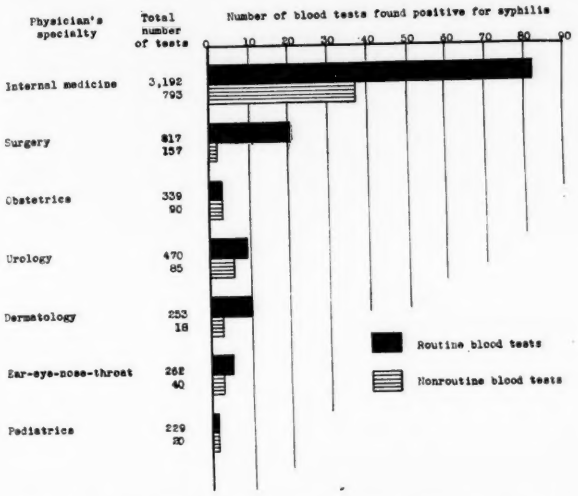


Fig. 3. Absolute number of blood tests found positive on routine examination by physicians in specialized groups compared with results from nonroutine blood tests.

and found positive with the total number tested as the base. Furthermore, it was impossible to say to what extent the tests were actually routine. However, there is sufficient evidence to indicate that there was certainly not the usual selection in patients for blood tests that existed prior to the survery period.

Figure 3 was designed to bring out the value of routine testing of blood for syphilis regardless of the physician's special field of medicine or surgery. In practically every branch of medicine the physician found a larger number of infected individuals than he had in a similar period in which the blood tests had not been a routine procedure.

While the prevalence rates for syphilis per 1,000 population reach a plateau about age tewnty-five and begin to decline at about age forty-five, the proportion of positive bloods in the survey shows a general upward trend with increasing age. The prevalence rates are based on cases actually under treatment. The increase in the rate of positive bloods per 1,000 bloods examined results either from an over-accumulating number of persons completely neglecting treatment or else lapsing from treatment before they receive sufficient therapy to reverse the blood test to negative.

The curve for positive blood tests for syphilis based on those examined in the period sixty days prior to the survey has not been presented. There was an insufficient number of bloods examined to subtantiate the apparently erratic changes in

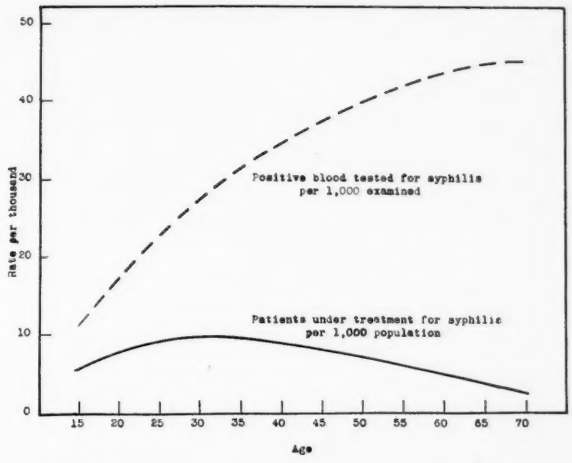


Fig. 4. Frequency of syphilitics detected by routine blood tests in given age groups compared with those under medical care.

TABLE I. POSITIVE BLOOD TESTS PER 1,000 BLOODS EXAMINED DURING SEROLOGIC SURVEY AND IN PRECEDING PERIOD AND THE RATE PER 1,000 POPULATION IN GIVEN AGES UNDER TREATMENT OR OBSERVATION FOR SYPHILIS, INGHAM COUNTY, MICHIGAN, 1938

Age	During Serologic Survey	Preceding Serologic Survey	Rate per 1,000 population under treatment or Observation for Syphilis
	Rate per 1,000 bloods examined		
0-4	17.8	16.3	1.5
5-9	–	–	.5
10-14	–	*	1.3
15-19	8.7	35.7	3.0
20-24	13.6	42.4	6.0
25-29	20.8	71.5	6.7
30-34	31.1	33.5	5.8
35-39, 40-44, 45-49	24.0	48.9	6.5
50-54, 55-59	39.1	74.8	5.5
60-64, 65-69	34.1	38.3	2.7
70-74, 75	48.9	63.1	.9
	–	–	.5

*The small number of persons in age group 10-14 make the rates for positive bloods too unreliable; therefore, they have been excluded.

the percentage of positive tests found in given ages. In the curve based on the blood tests made during the survey period some reservation must be made, since the total patient population for which these blood tests were made, were not available to the investigators. The results are presented with the hope that other surveys of a similar nature will be made which may confirm these findings. It is of interest to note that the percentage of positive blood tests found among applicants for marriage licenses since the enactment of the Michigan antenuptial physical examination law on October 29, 1937, tends to confirm the results obtained in the serologic survey period. In the three months following the passage of the act, 5,693 of these applicants were examined in the Michigan Department of Health Laboratory, seventy-nine or 1.4 per cent of whom were positive. These data represent approximately one-half of the applicants for marriage licenses in Michigan during the reported period.

In Table I the rates for positive bloods in both the survey period and that preceding it, are shown. The prevalence rates per 1,000 population for syphilis are also shown. If blood tests were performed more than once for the same individual during the survey periods, they were excluded from the study.

2. *Results of the census of patients with venereal disease actually under observation and treatment.*—In Ingham County the number of individuals found actually under observation and treatment for venereal disease exceeded by 40 per cent those who were reported to the state health authorities. The incompleteness of current reporting of cases of venereal disease to the health departments limits the effectiveness of a preventive and control program, first, because without the knowledge of the extent of the disease it is impossible to secure an allocation of funds commensurate with the prevalence of venereal disease in relation to other communicable diseases; second, that it destroys the opportunity for the early detection and treatment of probable sources and exposed contacts; third, it prohibits the return of lapsed patients to the physician and thereby creates a dangerous and hidden source of infection through mucocutaneous relapses in inadequately treated syphilitics.

TABLE II. ANNUAL ATTACK RATE FOR GONORRHEA PER 1,000 POPULATION, INGHAM COUNTY, MICHIGAN, 1938

Stage of Gonorrhea on Admission	WHITE					
	Male		Female		Total	
	Patients	Rate per 1,000	Patients	Rate per 1,000	Patients	Rate per 1,000
Acute	684	11.5	96	1.7	780	6.7
Chronic	180	3.0	48	.8	228	1.9
Complications	24	.4	36	.6	60	.5
Total	888	14.9	180	3.1	1068	9.1

No new cases of gonorrhea among Negroes reported.

TABLE III. ANNUAL ATTACK RATE FOR SYPHILIS PER 1,000 POPULATION, INGHAM COUNTY, MICHIGAN, 1938

Stage of Syphilis on admission	WHITE				COLORED				Total	
	Male		Female		Male		Female			
	Patients	Rate per 1,000	Patients	Rate per 1,000	Patients	Rate per 1,000	Patients	Rate per 1,000	Patients	Rate per 1,000
Congenital	9	.15	27	.5	6	7.0	3	4.2	45	.4
Early	69	1.2	78	1.4	18	21.0	12	17.0	177	1.5
Latent	90	1.5	45	.8	9	10.5	6	8.5	150	1.3
Neurosyphilis	36	.6	18	.3	–	–	–	–	54	.5
Late unspecified and other	108	1.8	51	.9	–	–	–	–	159	1.3
Total	312	5.2	219	3.8	33	38.4	21	29.7	585	4.9

No new cases of cardiovascular syphilis detected during survey period.

The annual attack rate for gonorrhea in this community is 9.1 per thousand, and for syphilis, 4.9 per thousand. These rates include both early and late cases seeking

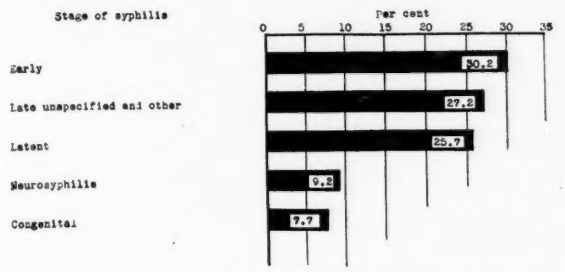


Fig. 5. Proportion of patients in various stages of syphilis admitted to treatment for the first time during the year 1937, Ingham County, Michigan.

treatment for the first time for their infection. The attack rate for acute gonorrhea is 6.7 per thousand, that for early syphilis 1.5 per thousand, which is no higher than the rate found through surveys of other comparable communities.

These rates become a living drama when expressed in individuals. Seven hundred and eighty individuals acquire gonorrhea each year among the 118,000 individuals of Ingham County, and another 177 acquire syphilis. As is shown subsequently in this report, through inadequacy of treatment, two out of three of these individuals will be added to the ever-accumulating load of potential treatment problems of the next decade. Urgent need for more alertness in the detection of syphilis in pregnancy is evidenced by the failure to give thirty mothers sufficient treatment to prevent the transmission of syphilis to the child during a one-year period.

From an economic standpoint these children are not the only toll which syphilis exacts from the community. There is the patient who has neglected to seek treatment during the early stage of the disease and seeks the physician only when his infection has progressed to cardiovascular or central nervous system syphilis. This latter group forms 9 per cent of those who sought treatment during the year.

The rate for syphilis is higher in the white male than in the white female. The rate for the colored race is approximately six times that for the white race. However, the treatment of the negro is a minor problem because this group of individuals form only slightly over 1 per cent of the population of Ingham County.

TABLE IV. DISTRIBUTION OF PATIENT POPULATION UNDER TREATMENT FOR VENEREAL DISEASE BY ALL SOURCES BY RACE AND SEX, INGHAM COUNTY, MICHIGAN, 1938

Race and Sex of Patient	Number of Patients	Percentage Distribution	Prevalence Rate per 1,000
White male	393	57.0	6.6
White female	256	37.2	4.5
Colored male	22	3.2	25.6
Colored female	18	2.6	25.5
Total	689	100.00	5.8

TABLE V. DISTRIBUTION OF PATIENT POPULATION UNDER TREATMENT FOR VENEREAL DISEASE BY RESIDENCE, INGHAM COUNTY, MICHIGAN, 1938

Residence of patient	Number of Patients	Percentage Distribution
Lansing	546	79.2
Ingham County	100	14.5
Out of County	43	6.3
Total	689	100.0

Seventy-nine per cent of the patients with syphilis and gonorrhea reside in Lansing. This percentage of distribution approximates that of the general population.

The prevalence rates for syphilis and gonorrhea which indicate the constant patient population under treatment or observation for these infections in Ingham County are 3.8 per 1,000 population for syphilis and 1.9 for gonorrhea. The rate for early syphilis is 1.2 and for acute gonorrhea is 1.1.

Although 82 per cent of the patients with venereal disease were in the hands of 31 per cent of the physicians in Ingham County, only a third of the physicians had no patients under treatment. It is apparent that the physicians in general in this community are syphilis conscious. Further evidence that the physicians of Ingham County have a "high index of suspicion" is revealed by the fact that 30 per cent of the patients under treatment for syphilis were in the early stages of the infection on admission.

A study of the physicians classified by the branch of medicine or surgery which they practice showed that 27 per cent of the gen-

TABLE VI. CONSTANT PATIENT POPULATION UNDER TREATMENT OR OBSERVATION FOR SYPHILIS AND GONORRHEA, INGHAM COUNTY, MICHIGAN, 1938

Stage of Infection on Admission	Number of Patients	Rate per 1,000 Population
Syphilis:		
Congenital	46	.39
Early	149	1.26
Latent	115	.97
Cardiovascular	3	.02
Neurosyphilis	35	.30
Late, unclassified	111	.94
Total syphilis	459	3.87
Gonorrhea:		
Acute	141	1.19
Chronic	69	.58
Complications	20	.17
Total gonorrhea	230	1.94

TABLE VII. DISTRIBUTION OF PATIENTS WITH VENEREAL DISEASE BY PHYSICIANS, INGHAM COUNTY, MICHIGAN, 1938

No. of Patients	Total Patients		Number of Physicians	
	Number	Per Cent	Number	Per Cent
None	00	00	46	35.4
1- 4	98	17.9	44	33.8
5- 9	158	28.8	24	18.5
10-14	69	12.6	6	4.6
15-19	85	15.4	5	3.8
20-29	100	18.2	4	3.1
30-39	39	7.1	1	.8
Total	549	100.0	130	100.0

NOTE—31 per cent of the physicians treat 82 per cent of the venereal disease patients.

TABLE VIII. PROPORTION OF PHYSICIANS IN VARIOUS BRANCHES OF MEDICINE OR SURGERY WHO HAD NO CASES OF VENEREAL DISEASE UNDER TREATMENT DURING THE SURVEY PERIOD, INGHAM COUNTY, MICHIGAN, 1938

Branch of Medicine or Surgery	Number of Physicians in Group	Number of Physicians Reporting no Cases	Percentage Distribution of Physicians Reporting no Cases
Internal Med.	75	20	26.7
Surgery	15	5	33.3
Obstetrics	5	3	60.0
Proctology	2	1	50.0
Urology	5	1	20.0
Dermatology	1	–	–
Eye, ear, nose and throat	12	9	75.0
Pediatrics	5	3	60.0
Neurology	1	–	–
Radiology	1	1	100.0
Total	122*	43	35.2

*This table includes physicians with private practice only.

eral practitioners treated no cases; 33 per cent of the surgeons and 60 per cent of the obstetricians. The ultimate control of syphilis is assured, provided every practicing physician is constantly on the alert to detect the early case. This is fundamental to the success of any program designed to prevent and to control syphilis.

Although the early detection of syphilis is of paramount importance, the gains made are quickly lost if the physician fails to hold the patient under treatment until he has been rendered noninfectious and protected against a disastrous outcome from the disease. Unfortunately, just this situation exists in Ingham County. Despite the fact that a higher proportion of patients have been detected in the early stages of syphilis in this county than in most communities throughout the Nation where surveys have been made, only one out of three of the patients have received the minimum required treatment to render them noninfectious before they disappear. This low percentage of individuals receiving prescribed therapy is due not only to the high percentage of individuals who disappear from treatment before they have been adequately treated but also because those who remain under treatment fail to adhere to a continuous schedule of therapy. Approximately one-half of the patients pursue a haphazard treatment schedule interspersing long lapses in the all-important first two years of the infection. This is true of patients under the care of either the private physician or the public clinic.

A study was made of the economic status of patients with syphilis and gonorrhea. It was found that two-thirds of the patients seeking treatment for early syphilis in Ingham County were on a low economic level. In fact, only 9 per cent of the early syphil-

TABLE IX. TREATMENT GIVEN PATIENTS WITH EARLY AND LATE SYPHILIS BY PRIVATE PHYSICIANS AND IN THE CITY CLINIC IN LANSING, DURING INDICATED PERIODS OF TREATMENT, INGHAM COUNTY, MICHIGAN, 1938

Amount of Treatment	PERIOD OF ADMINISTRATION							
	1-2 Years		2-3 Years		3 Yrs. or More		Total	
	Early	Late	Early	Late	Early	Late	Early	Late
	Private Physicians							
Heavy metal only	–	3	1	†	–	–	1	3†
Arsphenamine injections*								
1- 4	1	–	–	1	1	1	2	2
5- 9	–	–	–	2	2	2	2	4
10-14	2	3	–	4	–	4	2	11
15-19	–	5	–	3	–	2	–	10
20 or more	6	10	4	7	1	12	11	29
Total	9	21	5	17†	4	21	18	59†
	City Clinic and Others							
Heavy metal only	1	1	4	1	4	2	9	4
Arsphenamine injections*								
1- 4	–	1	–	–	3	2	3	3
5- 9	2	–	–	1	2	1	4	2
10-14	1	–	1	–	3	3	5	3
15-19	1	–	1	1	4	2	6	3
20 or more	–	–	2	–	1	3	3	3
Total	5	2	8	3	17	13	30	18

*The injections of arsphenamine are used as the index; the amount of interim heavy metal is not shown.
†Excluding oral administration to three patients.

TABLE X. COMPARISON OF THE SYPHILITIC PATIENTS WHO ARE STILL UNDER TREATMENT BY PRIVATE PHYSICIANS AND IN PUBLIC CLINICS WITH THOSE WHO ARE NO LONGER UNDER TREATMENT, SHOWING THE AMOUNT OF ARSPHENAMINE ADMINISTERED DURING SPECIFIED TREATMENT-OBSERVATION PERIODS

Duration of Treatment and observation in Years	PHYSICIANS					CLINICS AND OTHERS				
	1 to 19 Injections		20 or more Injections		Average	1 to 19 Injections		20 or more Injections		Average
	Number	Per Cent	Number	Per Cent	Inject.	Number	Per Cent	Number	Per Cent	Number Inject.
	Still Under Treatment									
Less than 1 year	110	81.5	17	31.5	11	61	68.5	1	16.7	7
1- 2 years	10	7.4	15	27.8	21	4	4.5	–	–	8
2- 3 years	5	3.7	10	18.5	25	4	4.5	2	33.3	17
3 years or longer	10	7.4	12	22.2	26	20	22.5	3	50.	13
Total	135	100.0	54	100.00	15	89	100.0	6	100.0	9
	No Longer Under Treatment									
Less than 1 year	19	67.9	–	–	8	10	71.5	–	–	4
1- 2 years	2	7.1	1	33.3	18	2	14.3	–	–	12
2- 3 years	5	17.9	1	33.3	16	1	7.1	–	–	16
3 years or longer	2	7.1	1	33.3	23	1	7.1	1	100.0	18
Total	28	100.0	3	99.9	12	14	100.0	1	100.0	8

TABLE XI. ECONOMIC STATUS OF NEW PATIENTS WITH SYPHILIS OR GONORRHEA, INGHAM COUNTY, MICHIGAN, 1938

Economic Status	SYPHILIS				Gonorrhea	
	Early		All Other Stages			
	Number	Per Cent	Number	Per Cent	Number	Per Cent
On relief	31	47.7	38	29.2	13	14.6
Poor	12	18.5	26	20.0	23	25.8
Moderate	16	24.6	49	37.7	40	45.0
Good	6	9.2	17	13.1	13	14.6
Total	65	100.0	130	100.0	89	100.0

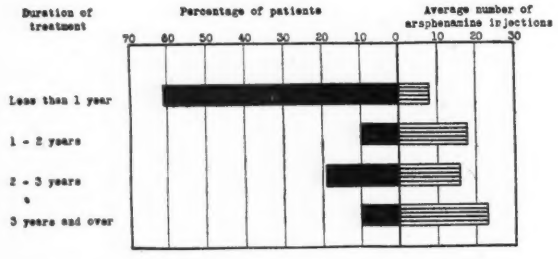


Fig. 6. Number of injections of arsphenamine with interim heavy metal administered by private physicians to 31 patients who disappeared, showing period of treatment, Ingham County, Michigan.

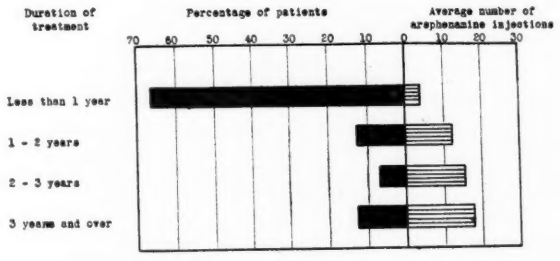


Fig. 7. Number of injections of arsphenamine with interim heavy metal administered by public clinics to 15 patients who disappeared, showing period of treatment, Ingham County, Michigan.

itics had an earning capacity of $3,000.00 per annum. A comparison was made of the economic status of early syphilitics with that of the forty-five million wage earners of the United States, as reported in "America's Capacity to Consume" by the Brookings Institute. It was found that the economic status of the two groups was similar. Thus, for every patient with syphilis who can afford to pay the private physician there are nine other syphilitics who cannot afford this care in the early stages. In the late stages of syphilis a higher proportion of those infected have moderate or good economic status. It is unfortunate that once an individual has a sufficient earning capacity to pay for the treatment of syphilis, the disease has passed beyond the stage when modern therapy can offer the greatest promise of "cure."

With gonorrhea, the average duration of treatment is shorter and therefore the cost is less so the economic status of the patient is not so important a factor in the control of this disease.

Present Detection and Treatment Facilities

Blood tests for syphilis as performed in the Michigan State Laboratories were found reliable both as to specificity and sensitivity by the United States Public Health Service Committee on Evaluation of Serodiagnostic Tests. The performance of blood serologic tests is not restricted to State Laboratories. Privately owned laboratories are registered and a control maintained on their accuracy in serodiagnostic work through the examination of unknown sera supplied approximately four times a year by the Michigan State Laboratory. Licenses are withdrawn whenever the private laboratories fail to meet the standard requirements of the State. The Michigan Department of Health provides Kahn antigen to all registered laboratories without charge.

In the present serologic survey, January 15 to March 15, 1938, the Michigan State Laboratory performed 88 per cent of the examinations. However, of the 360,000 serodiagnostic tests performed last year in Michigan 79 per cent were made by regis-

tered laboratories. Improved apparatus for delayed darkfield tests for syphilis recently have been made available. A very limited number of spinal fluid examinations are made.

PART II

State of Michigan Control Measures for Venereal Diseases

Act 272 P. A., 1919, was designed to protect the public health; to prevent the spreading of venereal diseases, to prescribe the duties and powers of the State Department of Health and of local health officers and health boards with reference thereto and to make an appropriation to carry out the provisions of this act. The State Department of Health, in carrying out the provisions of this act, requires from every treatment source an immediate report of every patient with syphilis, gonorrhea, or chancroid on blanks prepared and furnished to physicians and health officers for this purpose. To facilitate the proper treatment of infected individuals the State Department of Health makes available to physicians on request arsenicals and bismuth for the treatment of reported patients with syphilis provided the patient is unable to pay a sufficient fee to include the cost of drugs. This same provision for drugs is made to hospitals and clinics.

The distribution of drugs is the function of the State Department of Health. However, in those countries where a full-time county health unit is in operation the local health officer distributes drugs to treatment sources within his jurisdiction. Fifty-six of the eighty-three counties in Michigan have a full-time county health unit. Plans have been approved for the establishment of two additional county health units, one of which will be in Ingham County. This county health department is to be used as a field demonstration and teaching center for physicians taking postgraduate courses in Public Health at the Wayne University and University of Michigan.

A further function of the county health officer is the follow-up and return to treatment of those patients who discontinue therapy before receiving the minimum amount required to prevent the spread of the infection in the community. The State Department of Health has one field investigator assigned for follow-up service in those counties in which a health unit has not been established. During the past year the physicians in the rural area of Ingham County reported five patients delinquent from treatment, all of whom were returned and three exposed contacts, all of whom were examined, found to be infected, and placed under treatment. The success of this type of follow-up is largely dependent on the coöperation of physicians in reporting delinquent cases and probable sources and exposed contacts for investigation. Evidence that this type of follow-up is not wholly effective is found in the facts that only one out of three of the syphilitics under treatment by authorized medical sources sought care in the early stages of the disease, and further that only one out of three of those under treatment remained a sufficient time to receive enough treatment to render him noninfectious.

Since September 1, 1937, a full-time venereal disease control officer has been assigned to direct the program under the Bureau of Communicable Diseases. One of the objectives of the present plan of the Health Commissioner is to foster short review courses in current diagnostic and treatment practices in venereal diseases for the private physician.

A separate venereal disease control unit has been established in the City of Lansing under the direction of the City Health Department. This unit provides a venereal disease clinic for the treatment of the medically indigent. Treatments for persons infected with syphilis are given once each week, on Saturday mornings. Treatment of persons infected with gonorrhea are carried out five mornings per week in conjunction with other general medical care. No provision has been made for a separate prenatal clinic. However, routine serologic blood tests are made on all pregnant women. There are no evening clinics for the treatment of venereal disease. There is no adequate medical social follow-up available to this clinic. Evidence of the need for such service is found in the analysis of the performance of this clinic with regard to tracing the probable sources and exposed contacts and the inability to hold patients until they have received enough treatment to prevent the spread of the infection in the community.

Provision has been made by the city to treat those transients who are infected with syphilis. Every overnight transient is given a serologic blood test and an examination

for gonorrhea. The treatments for gonorrhea are given at the transient camp. Notification of the identity of all infected individuals is made to all camps for transients in the state.

Individuals in need of hospitalization because of venereal disease are admitted to the hospitals in the city of Lansing. Quarantine facilities at the City Contagious Hospital are available for the control of recalcitrant infectious individuals who persistently refuse to take or resume treatment.

The city of Lansing does not operate a municipal hospital for the general medical and surgical care of the indigent. Hospitalization of the indigent sick is provided for on a per diem basis in the two privately owned hospitals. These patients are given general medical and surgical care by the members of the Ingham County Medical Society. The society receives reimbursement for these services in accordance with an agreement with the City Board of Directors. In turn, the society offers certain privileges to its members payable from these funds. Under this plan, hospitalization for the indigent sick has been reduced to an average of five days per patient. Blood tests are made in these institutions whenever the physician requests this service. Therefore, they are not routine. During the serologic survey period routine blood tests were performed.

Summary

A public health committee of the Ingham County Medical Society requested the cooperation of the United States Public Health Service in determining the extent of the problem of venereal diseases in Ingham County. The committee proposed two methods for establishing the prevalence and incidence of these diseases:

1. A novel plan, that of a routine blood test on all patients coming under the care of each private physician in active practice in Ingham County during a sixty-day period (January 15 to March 15, 1938).

2. A census of cases of venereal diseases actually under treatment or observation by an authorized source of treatment within a given period (September 15, 1937, to January 15, 1938, for syphilis, and December 15, 1937, to January 15, 1938, for gonorrhea).

Through these two methods it was proposed to establish the ratio of under-treatment patients with syphilis to the potential treatment load.

During the two-month survey period the private physicians examined 7,600 bloods, as compared with 1,770 in the preceding two months. One hundred additional persons with syphilis were uncovered through the routine serologic survey.

The percentage of positives in the routine serologic survey was 2.4, as compared with 4.8 in the preceding sixty-day period. Naturally, the rate in the preceding sixty days was higher, since blood examinations were more or less limited to individuals in whom syphilis was suspected.

The results of the one-day census survey indicated that 3.9 per thousand individuals with syphilis were constantly under observation and treatment by an authorized medical source. Only one out of six persons in whom syphilis could be detected by a routine blood test was actually under observation and treatment for the disease.

In practically every branch of medicine or surgery a larger number of infected individuals were detected by the use of a routine serologic blood examination during the survey period than had been in a similar period in which the examination of the blood had not been a routine procedure.

The prevalence rates for syphilis per thousand population reach a plateau about age 25 and begin to decline at about age 45. The proportion of positive bloods in the survey shows a general upward trend with increasing age. The increase in the rate of positive bloods per 1,000 bloods examined results either from an ever-accumulating number of persons neglecting treatment or else lapsing from treatment before they receive sufficient therapy to reverse the blood test.

The annual attack rate for gonorrhea in this community, based on fresh infections seeking treatment, is 6.7 per thousand; that for early syphilis, 1.5 per thousand population. Annually, at least 780 individuals acquire gonorrhea and 177 acquire syphilis of the 118,000 residents of Ingham County.

Urgent need for more alertness in the detection of syphilis in pregnancy was evidenced by the failure to give thirty mothers sufficient treatment to prevent the transmission of syphilis to the child during the one-year period.

Neglect in seeking treatment in the early

stage of the disease was evidenced by the fact that 9 per cent of those who sought treatment during the year had progressed to central nervous system syphilis.

The data indicate that the physicians of Ingham County had a "high index of suspicion." This statement is premised on the fact that a higher proportion of patients were detected in the early stages of syphilis in this community than has been found in most communities surveyed throughout the nation. However, it was found that physicians of Ingham County were no more successful in holding patients until they had received the minimum required treatment to render them non-infectious before they disappeared than had been found to be true elsewhere. The proportion of patients who received sufficient treatment was only one out of three. Furthermore, there was evidence that those who do secure enough treatment before disappearing fail to adhere to a continhous schedule of therapy. Approximately one-half of the patients pursue a haphazard treatment schedule, interspersing long lapses in the all-important first two years of the infection.

A study of the economic status of patients with syphilis and gonorrhea indicated that two-thirds of the patients seeking treatment for early syphilis in Ingham County were on a low economic level. In fact, only 9 per cent of the early syphilitics had an earning capacity of $3,000 or more per annum. Thus, for every patient with syphilis who can afford to pay a private physician there are nine other syphilitics who cannot afford this care in the early stages. In the late stages of syphilis a higher proportion of those infected had moderate or good economic status.

With gonorrhea, the average duration of treatment is shorter and therefore the cost is less, so that the economic status of the patient is not so important a factor in the control of this disease.

APPLICATION OF THE SURVEY TO THE PRIVATE PRACTITIONER

HARTHER L. KEIM, M.S., M.D.
DETROIT, MICHIGAN

I am indeed pleased to be here and take part in this symposium, for I have the distinct feeling that medical history for the State of Michigan is in the making.

The obvious splendid coöperation, between the national, state and local health authorities and the Michigan State and Ingham County Medical Societies, foreshadows the adoption and workability of a venereal disease control program, which will be satisfactory to all concerned. This is in striking contrast to the apparent difficulties now encountered in a similar situation in a bordering state.

Judging from what has already been accomplished by this coöperative spirit and what is to be proposed later this evening, by your new Preventive Medicine Committee, there can be little doubt that in the not too distant future, a practical program will be in operation which will serve as a model for other units within the state, as well as beyond its borders, known, may I say, as, "The Ingham County Plan"?

The plan, when formulated and in operation, should recommend itself to all interested parties, namely: the Public (Public Health Agencies), the Patient, and the Private Physician.

The Public

Will receive maximum protection. This will be secured by:

1. Modern treatment to reduce infectiousness.
2. Trained contact and medical follow-up personnel.
3. Lay education.
4. Active flexible file for the control of infected cases.
5. Coöperation of pharmacists to prevent counter prescribing.
6. Continuation of serologic diagnosis survey.
7. Reporting of all cases.

The Patient

Will receive adequate treatment, skilled medical care, and maximum privacy. These will be secured by:

1. Financial support if necessary.
2. Postgraduate or refresher courses for physicians.
3. Routine serologic examination of every pregnant individual.
4. Available competent consultation.
5. Maximum privacy as can only be secured in the physician's office.

The Physician

Retains control of his patient and the important patient-doctor relationship is maintained.

However, if we as physicians are going to accept this responsibility, and its success or failure rests with us, we will have to be prepared to render "skilled medical care," in the fullest meaning of the term. Either one should be prepared to treat these diseases according to present day standards, or decide not to include them in his practice. With the plan functioning, facilities will then exist for the Prevention and the Detection of the genito-urinary diseases and it will be up to the physician to furnish that brand of modern, adequate and skilled medical care that will, in the shortest possible time, render the patient noninfectious and protect him against later serious sequelæ.

This, then, brings me to my main theme, "The Modern Treatment of Syphilis." Because we are this evening primarily interested in the control of the genito-urinary diseases I will confine my remarks to the treatment of early infectious syphilis.

I have long felt that we as physicians are not only privileged, but duty bound, at the time the infection is discovered, to secure such understanding and coöperation from the patient that he will continue his antisyphilitic therapy to a successful conclusion. This is the opportune time to gain the patient's confidence and mold his reactions and responsibilities to his new-found handicap. This can be accomplished by explaining to him in understandable terms the seriousness of his disease without frightening generalities; its communicability; his chance for cure; and what in time, effort and finance will be required of him to avoid unnecessary later accidents. Such time and effort on the part of the physician is usually well repaid, and even the less responsible group, with such an introduction to the disease, are more apt to continue long enough to at least decrease the probability of infectious relapse.

Impress upon your patient that early syphilis is curable. We know that occasionally the disease is self cured or cured with little treatment, but not knowing which cases may be resistent we must, of course, give all cases the benefit of a minimum amount of therapy.

The Rôle of Arsenic, Bismuth and Mercury in Modern Treatment

Two metals, namely, arsenic and bismuth, properly administered over a sufficiently long period of time, will bring to a successful conclusion the vast majority of all cases of early syphilis.

A few known facts about these medicants:

1. Arsenic is the controller of infectiousness.
2. Bismuth is the defensive mechanism stimulator.
3. Syphilis has been cured with either alone, but the margin of safety is too small.
4. Most satisfactory results are obtained by their alternate use.
5. Neoarsphenamine plus bismuth is now known to be as effective as old arsphenamine plus bismuth, the latter making up for the lesser arsenic content of neoarsphenamine.
6. Treatment systems including bismuth call for a dosage of 100 mg. of metallic bismuth per week. The insoluble salt is preferred.
7. Mercury has little or no place in the treatment of early syphilis.
8. Mapharsen is rapidly winning a place in the therapy of early syphilis.

Some Principles of Modern Treatment

The time is well within my memory when syphilologists were apt to frown upon any attempt to routinize syphilis therapy. However, painstaking study over the past decade by the Coöperative Clinical Group, the United States Public Health Service and the League of Nations Syphilis Commission has given us a systematic schedule of early syphilis therapy, confirmed in principle and fact, which we are striving to have uniformly adopted by the profession. The present schedule of choice is the American system of continuous treatment, as opposed to the British intermittent treatment technic.

Recent re-examination of the Coöperative Clinical Group statistics reveals some of the reasons for the selection of the continuous system.

1. *Continuity of treatment*
   a. Was found to be more effective than intermittent in all types of early syphilis.
      (1) Fewer relapses (13% as opposed to 21%)
      (2) Satisfactory results (2 yrs.) (79% as opposed to 65%)
      (3) Serologic reversals in 1 yr. (82% as opposed to 37%)
      (4) Latent syphilis-satisfactory results (49% as opposed to 37%)
   b. Continuous treatment produces no more serious accidents than intermittent.
2. *There is no need to fear liberal dosage*
   a. Full dosage no more toxic than reduced dosage
   b. Full dosage more effective than over-cautious or reduced dosage.
   c. Dosage should be determined by weight, not sex.
   d. Average dose
      0.6 grams neoarsphenamine (0.45 to 0.75 grams)
      0.45 grams old arsphenamine

3. *Prolongation of treatment—(longer series)*
   a. Experience shows that longer series result in no more accidents than shorter courses.
   b. Toxicity factor in modern systems is not a dosage or longer series factor. Rather:
      (1) Faulty administration (too rapid)
      (2) Extravasation of arsenical
      (3) Idiosyncrasy
      (4) Declining tolerance with passing of years
      (5) Functional damage (syphilis or other causes)

Continuous Treatment Schedules

Giving thought to the above facts, we can then proceed to systematize minimum treatment for early and latent or occult syphilis (i.e., positive blood test, no signs, no symptoms and a completely negative spinal fluid) in early and middle adult life with dosage by weight, no distinction between men and women, continuously administered with alternate but combined use of arsenical and bismuth, as less complicating inducing, than concurrent or simultaneous use.

The Coöperative Clinical Group recommends what has come to be known as the 30-60-0-3 minimum system. This refers to 30 injections of arsenical, 60 of bismuth, no rest period and three years' observation. It is a convenient way to remember the figures. Numerous modifications of this schedule are in vogue. Our own Advisory Committee on Syphilis Control with Dr. Shaffer as chairman prefers that arsenical 1, 2 and 3 be given during the first seven days, to be followed with five weekly intravenous injections of the arsenical and then alternate with courses of bismuth until 40 of each are given.

The recommended schedule for latency, i.e., syphilis after five years, follows the so-called 24-60-100 plus plan. Beginning with 8 weekly injections of arsenical, followed with 10 to 12 weekly injections of bismuth, the schedule is continued without rest period until the quota of 24 arsenicals is given. Conservatism would suggest inauguration of therapy in latency with bismuth rather than the arsenical, to avoid the possibility of shock in a patient with a hidden active lesion. The 100 plus refers to the continuation in selected cases of a course of heavy metal yearly, for three to five or even ten years, which definitely helps the ultimate result.

Such procedure (24-60-100 plus) in latency reverses 70 per cent of positive blood tests, reduces probability of progression from 20 to 30 per cent to 2.5 per cent. The time in life that one should modify this schedule does not depend upon the patient's years, but upon the individual's state of health and probable ability to tolerate the treatment.

Syphilis in Pregnancy

Another important division of the practicing physician's syphilis problem is that of the pregnant patient. It is obviously not possible here to outline the equivalent of the above schedules, but the following recommendations should be included in the management of every pregnant syphilitic.

1. Serologic examination of the blood should be done before the fifth month if possible.
2. Begin treatment when possible before the fifth month (91 per cent healthy children against 61 per cent when treatment is begun later)
3. Every infected woman should be treated through every pregnancy, whether blood is positive or negative.
4. Have syphilitic mother limit her family so as to avoid accumulative over treatment.
5. Estimated tolerance of the woman for treatment must be individually determined, not routinized.
6. Remember that the pregnant woman tolerates arsenicals better than the nonpregnant syphilitic woman (one-half as much dermatitis and one-fifth as much jaundice)
7. Try for Coöperative Clinical Group minimum of 10 arsenical and 10 bismuth injections.
8. Prefer alternate continuous treatment, but if time is short, give simultaneously, provided mother's condition is good and elimination unimpaired.
9. End treatment before delivery with an arsenical injection. Then continue postpartum to satisfactory conclusion with one of the continuous schedules.
10. Frequent urine and blood pressure examinations.
11. No induced abortions, no lumbar puncture until after delivery.
12. Postpone malaria, tryparsamide or other special treatment until after delivery.
13. Use child's tenth day own blood for serologic test (jugular vein), not cord blood.
14. X-ray of fetal bones and microscopic examination of placenta should be utilized in doubtful cases.

Spinal fluid examination is essential to the intelligent management of every case of syphilis treated. In early and latent syphilis this examination should be made at the completion of the first arsenical course, six to eight weeks after the inauguration of intravenous therapy. This allows some time to gain the patient's confidence and alter his prejudice against this procedure.

The prognostic grading of spinal fluids divides itself into:

(after Stokes)

GRADE	I (MILD)	II (MODERATE)	III (SEVERE)
BLOOD	Negative or Positive	Negative or Positive	Almost invariably strongly positive
CSF QUANTITATIVE WASSERMANN	Negative 0.2 c.c. to 1.0 c.c.	Negative 0.2 c.c.; Positive 1.0 c.c.	Strongly positive 0.2 c.c. to 1.0 c.c.
CELLS	5 to 25	25 to 100	7 to 100 plus
PROTEIN	1 plus	2 plus	3 plus
COLLOIDAL TEST	1110000000 0000011000	00244543100	5555543100
PROGNOSIS	Clears with standard or routine treatment for the disease.	Requires 1 to 2 years additional standard plus intraspinal or fever.	Will not clear without fever or tryparsamide, or both.

Moderate or severe spinal fluid findings which do not respond to routine treatment warrant consultation and specialized management. It is axiomatic that no case of syphilis can be discharged as cured without spinal fluid examination.

Reactions to arsenical medication unavoidably accompany syphilis therapy, but careful attention to administration and to patient will not only reduce the number of such accidents, but likewise their severity. Grave reactions frighten and alter therapeutic procedure, minor disturbances lead to lost confidence, lapse in treatment schedule, prolonged infectiousness and unsatisfactory final results.

Grave reactions are definitely preventable. Attention to intercurrent, focal and skin infections, all of which tend to broaden the allergic base, will definitely improve the patient's arsenical tolerance. Approximately 90 per cent of these serious arsenical accidents are preceded by one or more minor disturbances, which, if recognized, should serve as danger signals. Gastro-intestinal upsets, itching, urticaria, slight rashes, and the like should induce cautious therapy and prevent the administration of that last injection which may throw the patient into one of those dreaded arsenical mishaps.

Finally, let me say again that the success or failure of this ambitious plan for the control of the genito-urinary diseases in Ingham Country rests with the practicing physician. This is particularly true of the epidemiologic control of these diseases, the newest form of attack upon the infectiousness problem. As I said before, it begins at the time of the first office visit when the seed is sown for a coöperative doctor-patient relationship, which will not only result in sustained therapy, but will furnish us with information to make possible successful contact tracing at the hands of our proposed trained personnel.

The Patient Himself

The phenomenal advances of medical science have so largely engrossed the attention of students and teachers of medicine that our schools are charged frequently with failure to teach the embryo physician that his patients are human beings and that he must treat individuals, not merely manifestations of a disease. One of our leading universities has made a definite effort to counteract this tendency and their experience of seven years seems to have more than justified the undertaking. Elswhere in this issue, Bailey and Weiskotten describe the procedure employed at Syracuse to demonstrate to undergraduate students the importance of considering the personality of the patient and all the factors, environmental and otherwise, which, impinging on him, inevitably influence and perhaps greatly modify his reaction to disease. Especially wholesome in the Syracuse plan is the stress on having the student himself investigate the social, economic, religious or industrial relationships of his patient instead of depending on the second hand information relayed by a social worker. On the doctor is laid the responsibility for understanding all the adjustments that may be needed in order to give to the patient the best possible chance of recovery. An index of the success of the method may be found in the work recently published by a Syracuse graduate, "Disease and the Man," which is briefly reviewed in this issue of THE JOURNAL.—*Jour. A. M. A.*, Dec. 25, 1937.

PROGRAM FOR CONTROL OF GENITO-INFECTIOUS DISEASES IN INGHAM COUNTY, MICHIGAN

R. S. BREAKEY, M.D.
Secretary, Preventive Medicine Committee
LANSING, MICHIGAN

Submitted by the Public Health and Preventive Medicine Committee of the Ingham County Medical Society following consultation with the United States Public Health Service; the Commissioner of Health of the State of Michigan, D. Gudakunst; the director of Laboratories, C. C. Young; and the chairman of the Michigan State Medical Society Syphilis Control Committee. Grateful appreciation is herewith extended to the above departments and individuals as well as to the officers and the Council of the Michigan State Medical Society and the Lansing Department of Health for their invaluable assistance in making possible the survey presented.

This survey has been carried out by the Ingham County Medical Society as a whole, the original work having been begun more than two years ago. Recommendations submitted are based upon conclusions drawn from three particular viewpoints.

The Ingham County Medical Society is proud of the fact that nowhere else has there been made a survey of physicians by the physicians themselves, as was completed here eighteen months previously. They further take pride in the fact that they have themselves largely defrayed the expenses of the survey just completed. It must appear that the Society has indeed kept faith with the community and justified its original statement at the time of contractual relationship with local authorities in the care of the indigent sick, that monies received for such care would be used for the good of the people as a whole, as well as for the improvement of the standard of medical practice within the area involved.

The effort by which the Ingham County Medical Society has contributed both directly and indirectly is indeed unique. However, it must appear a waste of effort, time, and funds should not an endeavor be made to correct or eradicate such flaws as may have been uncovered.

With the facts now available it is possible to plan a program and to seek funds with which to carry forward not only the detection of these diseases under consideration but to insure a procedure of adequate treatment, and we urge your earnest consideration of the following recommendations.

We shall bring up for consideration various aspects of this problem under six general headings:

I. Case Finding
II. Control and Treatment
III. The Economic Factors Involved
IV. Coöperation of the Departments of Health
V. Education: Lay and Professional
VI. Administration

I. Case Finding

Let us first compliment ourselves upon the fact that this survey has proven that the early detection of syphilis in this community is approximately twice as great as in other communities, and that we have, as Dr. Aselmyer has so well expressed the situation, "A high index of suspicion." It may be well pointed out that many of the cases seen in the later manifestations were undiagnosed elsewhere or were self-treated in their early stages. From this latter viewpoint we must consider the educational factor. We have, however, failed to discover sources or contacts to any appreciable degree, though we do recognize, as is demonstrated by our previous survey, that every infected case represents another so infected. In this connection, as will be pointed out subsequently, a specially trained worker in this field, operating from the individual physician's offices, would be of inestimable value.

II. Control of the Patient

In nine out of ten cases the economic factor enters the picture to a more or less overwhelming degree. Patients are lost or disappear solely because of this economic factor.

These venereal patients may be divided roughly into three groups[4]; first, a small proportion who are so emotionally prostrated by the infection that they will adhere strictly to advice and follow all treatment rules to the letter. Second, and by far the

greatest group, those individuals who are "open to conviction" and may be influenced by understanding discussion to carry their treatment through to completion. Third, another small group who are utterly indifferent to their own personal outcome and equally so of the consequences to those with whom they come in contact. Considering the second group, the care and time to be spent at the first visit, which is truly so many times neglected, is worthy of emphasis. The availability of a social contact worker, already mentioned, will also be of great assistance in control of both of the latter two groups. The unreported patient who disappears is a lost patient, as well as a public menace. It was found in the survey conducted early in 1937 that many physicians did not wish to so report. We must recognize that the failure of physicians in Ingham County to completely report these cases has hampered and will hamper a successful control program. These two surveys have been completed for the purpose of forming a base line in establishing a true control program. The incidence of cases treated and those reported shows a marked discrepancy in that just completed, as well as that conducted previously. Unless a true analysis is available, funds, which it is proposed shall be allocated for the remuneration of the individual physician for the treatment of patients in the low economic bracket, will be grossly inadequate. Cases will be lost and our obligation to the community will remain only partially fulfilled.

III. Economic Factors

In the report just submitted by the United States Public Health Service it was pointed out that nine out of ten luetics could not afford minimum standard treatment. The income base which was chosen in estimating the above ratio was three thousand dollars per year. It is the sense of this committee that that base line has been placed considerably too high and this committee wishes to point out that 43 per cent of the physicians in the state of Michigan were found to have an annual income of less than twenty-five hundred dollars per year.[5] It is certainly true, however, that a very large proportion, which might reach 75 per cent, cannot stand the financial drain of continued regular treatment without assistance.

It is manifestly important that funds be made available for the operation of any program for the control of communicable disease, but even more particularly so when one considers the fact that the peak of these infections is reached at the age of twenty-five years, at which time few individuals are self-sustaining to a degree sufficient to stand the strain of anti-luetic treatment. It is the province of your committee to maintain this group of individuals under treatment by the individual physician, but it is a fundamental necessity that the physician should be remunerated for such treatment from the viewpoint of the patient, the common good, and that of the physician. It is true that the economic burden upon the physician and patient has been lessened to some degree by the state with the rendering available free therapeutic agents for such patients as are in economic stringency. Nevertheless, it is equally true that it appears advisable for the individual physician to be reimbursed from public funds according to a minimum fee schedule for such treatment. In many cases it may well be possible for the patient to make some payment, to which might be added a balance from public funds to compensate the physician up to such minimum fee schedule. Such recommended minimum fees would be understood to apply only to those in the lower economic group. Therefore, we feel that the treatment of venereal disease should and can be maintained under the guidance of the individual practicing physician as advocated by the President of the Michigan State Medical Society and the Committee on Syphilis Control, and that the local clinic should care for only those patients who could not be or would not be cared for by private physicians. It is notworthy that Donald Gudakunst,[2] Commissioner of Health of the State of Michigan, stated:

> "It is our contention that the treatment of syphilis rightly belongs in the hands of the private physician, for it is here that the maximum benefit will be obtained from treatment. It therefore becomes a problem of the Health Department to provide ways and means of giving treatment to those who are unable to finance their own care. . . . The clinics are necessary and do fulfill a definite function of completing the job of supplying treatment to all persons, but they should not be pushed to the foreground as the most desirable method of administering skilled care. The cost of treatment is relatively expensive. Therefore, the state should be able to assure every afflicted person of an adequate amount of care. This in many instances will mean the payment of the physician by the state for services rendered in his own office to indigents."

The contrary view is expressed by R. H. Riley,[6] Director of Health of the state of Maryland. This was pointed out by the president of the Michigan State Medical Society[1] in his letter of April 23 to all members of the Society. Riley states, "More than a year ago the State Department of Health operated a total of thirty-five clinics, all of which were free for the treatment of syphilis. Every county of the state was provided with at least one; seven counties had more." It appears that we have been blessed with a far-seeing Commissioner of Health.

IV. Coöperation of the Departments of Health

A. It is further axiomatic that any such program must have some point of centralization and general administration, and that, by law, it shall be placed in the hands of the City Health Director as it would pertain to the city of Lansing, and the health officer of the new county health unit as it might pertain to the remainder of Ingham County. However, the successful administration of any such program must rest upon the integral coöperation of the members of the profession under this jurisdiction and will depend upon the individual physician, reporting all cases of communicable disease, including those of genito-infectious origin. It should further include the reporting of cases lapsed from treatment in order that they may be returned to treatment, and lastly, it should include the reporting of all cases discharged as cured. Without this simple array of data, as previously pointed out, our future program will be crippled, sources of infection will remain unknown, and any allotment of funds would be made upon an inadequate basis. In addition, further factual data, which it is hoped to compile, would be erroneous. We have seen that we have been at least 40 per cent negligent in our reports in the past.

B. It is recommended that the Departments of Health maintain an active file of infected cases under treatment and that this file be of an elastic nature, permitting the recording of patients transferred from one physician to another or those who have lapsed from treatment, in order that the number of known infected individuals not under treatment may be minimized and that the coöperation of the individual physician from the viewpoint of reporting such cases as previously mentioned be obtained to a greater degree.

C. In view of the overcrowded situation at the local clinic and in view of the fact that these cases present an even greater problem than that of the private patient,[3] it is urged that facilities at this clinic be improved and that this question be referred to a special committee for study. Such committee should include the city physician and representatives from the Board of Health and the Public Health Committee of the Ingham County Medical Society. Also, in consideration of the fact that special equipment, knowledge, and ability are required for the recognition of the early manifestations of late syphilis, expert consultation should be made available as may be necessary from the viewpoint more particularly of cardiovascular, central nervous system, and visceral syphilis. These consultants should be remunerated at a minimum rate of from three to five dollars per case.

D. That the Department of Health obtain such necessary equipment[7] for tabulating and recording these cases for statistical material maintained by the United States Public Health Service in order that the results and progress of this control program may be evaluated in the future.

E. It is to be further recommended that a specially trained contact individual be added to the personnel of the departments of health for both the city and county. It has been pointed out that, "The employment of a confidential persuasive approach to elicit a voluntary response from the patient, in the hands of a trained individual, is about half again as productive of epidemiologic information as is the untrained coercive approach." This from Norman R. Ingraham, Jr.,[3] quoted in *Venereal Disease Information,* March, 1938. Such a trained worker should operate from the individual physician's office with the close coöperation of each physician. It is worthy of emphasis that the physician who in the past has been afraid of losing his patient has already lost the one who does not return, and, further, has possibly liberated upon the community an actively infected case without thought of possible consequences. In the experience of one of us, simple contact letters from the department of health to the patient, reported

as delinquent, returned fourteen of sixteen cases so reported to this physician for continued treatment.

V. Education—Lay

A. This matter has already been under way and has continued through national organizations, the United States Public Health Service, State Medical Society, the State of Michigan, and by our own County Society, through the medium of published articles, advertisements, lectures, and radio broadcasts. Much has been accomplished from this point of view. We are, in this community, carrying our efforts further by reaching individuals of the adolescent age in both of our city high schools, and it is noteworthy that an increasing number of patients suffering from either syphilis or gonorrhea are consulting the State Department of Health and our local health department for advice and recommendations as to treatment.

It is urged that these educational programs be continued and enlarged and that all members of this society be requested to accept invitations or suggest speakers for the presentation of the problem of genito-infectious diseases to lay groups of any type. However, said members to do so only after consultation with, and with the advice of, the to be proposed Sub-committee of Venereal Disease Control. This latter suggestion is made in view of the fact that our efforts have not been in the past standardized and unfortunately there have occurred some misquotations upon the part of individual speakers. It must appear desirable to all that no contradictory statements be made.

B. It is of prime importance that the closest coöperation be sought with the pharmaceutical profession in an effort to eliminate counter prescribing and self-treatment by the patient, which so often only masks an active or latent infection and leads to ultimate disastrous results. This fact alone unquestionably explains many luetics undiagnosed until tertiary manifestations have become evident. It is suggested for consideration that all druggists in this community be mailed copies of such resolutions as may be ultimately adopted by this society.

Education—Professional

A. It is to be reiterated that emphasis be placed upon the importance of the first visit to the physician and it is urged that more considerable time and care be spent at this time. We are all contributing much, as has already been pointed out, to the control of the patient, but it is further important that we coöperate individually in sending adequate reports to our respective health departments.

B. It is desirable for the purpose of further study, as well as the discovering of additional unknown luetics, that the program of the sero-diagnostic method employed during the recent survey be continued within the capacity and ability of the physician to do so, and, as a corollary to this, that routine sero-diagnosis be carried out upon all pregnant women. In fact, this should be regarded as of equal importance with progress urinalyses and blood pressures in such cases. During the two months immediately preceding the 60-day survey period, 1,770 sera were submitted; during this survey 7,600; and in the next 60-day period 3,141, an increase of 1,371 over the interval prior to the survey.

C. It is suggested that the Ingham County Medical Society during the ensuing year inaugurate a two-day clinic for instruction of its own members as well as others who might wish to attend, as to the minimum standards of treatment, epidemiology, complications, reactions, et cetera, for the purpose of increasing our own knowledge and improving our technic in these matters, such clinics to be entirely separate from the annual clinic and repeated if and when deemed advisable. The facilities for such postgraduate courses will be greatly increased in view of the recently established County Health Unit. Doctor Gudakunst has suggested that there could be transported from Detroit typical clinical material for use in such clinics. We must appreciate that two out of three of our early diagnosed cases, of which we might boast, have received grossly inadequate treatment from the viewpoint of protecting against infectiousness and that only one in five has been protected against ultimate disastrous results. It is to be recommended that the standard of treatment of the Committee on Syphilis Control of the Michigan State Medical Society be accepted within this community and that each physician familiarize himself with this minimum standard treatment.

It is to be recognized that serologic reports should not be used as criteria of cure, but rather the courses of treatment received.

VI. Administration

As previously mentioned, the direct administration must of necessity rest in the hands of the Departments of Health, with the coöperation and guidance of the Ingham County Medical Society. It is suggested that the name of the Public Health Committee be changed to that of the Preventive Medicine Committee, which is in harmony with the similar committee of the Michigan State Medical Society. It is also recommended that a sub-committee of the proposed Preventive Medicine Committee be established as a permanent committee; namely, a Venereal Disease Control Committee, this committee to work in close harmony with the departments of health of the city and county on these matters and to maintain the care of the syphilitic and gonorrheic patient by the individual physician; to furnish aid and assistance to such physicians; to manage and direct a proposed postgraduate clinic if endorsed by the society; to follow and report all progress, to handle, supervise, and edit all publicity. It should be the duty of such committee to work with the physicians in the interest of the public and to maintain as far as possible the status of the family physician and the individual patient. In view of the fact that an increasing number of individuals are consulting various health agencies for advice as to treatment of these infections, names of physicians attending a proposed clinic should be placed upon lists with these health agencies for reference of such patients.

It is worth reiterating that successful administration of any program must rest upon the integral coöperation of members of this society.

In closing, it is recognized that, while we have excelled in diagnosis, we have been remiss in treatment and that, in addition, treatment must be two-fold: first, to render the infected individual non-infectious to others, and secondly, to protect him from ultimate disastrous results of infection, thus minimizing the incidence of public charges and ultimate expense to the community as a whole, as well as ourselves.

The possibility of securing a contact worker through Social Security funds is very considerable, as is that of remuneration, as suggested, of the individual physician for the patient in the lower income bracket. It is our aim in this effort that as many patients as possible be offered treatment at the hands of the individual physician in contradistinction to that of a clinic. It is worthy of emphasis that the program suggested for establishment of such a two-day postgraduate clinic, both didactic and clinical, is in harmony with the principle of the Society for improving the standards of the practice of medicine within this community and our efforts in this behalf must be regarded as sincere by local governing bodies.

The following program of control is therefore submitted:

1. That a sub-committee of the Preventive Medicine Committee be appointed to be known as the Venereal Disease Control Committee, such committee to be a standing committee of the Society, appointed by the president.

2. That the function of this committee be as already described in the preceding report.

3. That it is the sense of the Ingham County Medical Society that treatment of venereal disease be maintained under the guidance of the individual private physician and that the clinic treat only such cases as cannot be so handled.

4. That it be recommended that venereal disease contact workers be added to the Lansing and County Departments of Health and that it be desirable that such individual receive his training in a special course given by an accredited authority.

5. (a) That in addition to free drugs, certain public funds or public monies be made available for minimum remuneration of the physician in the treatment of these cases. That the patient should pay within his capacity and the deficit between such minimum fees be made from public funds mentioned. That such minimum fees be agreed upon among the members of the Ingham County Medical Society as two dollars for intramuscular therapy and three dollars for intravenous. (b) In uncomplicated gonorrheic cases the minimum fee be one dollar.

6. That improved facilities be made available for the City Clinic for the treatment of completely indigent patients.

7. That competent consultation for complications be made available at a rate of remuneration of from three to five dollars per case.

8. That educational programs of lay groups be continued and increased under the guidance of the Sub-committee on Venereal Disease Control.

9. That the Ingham County Medical Society during the ensuing year inaugurate a two-day postgraduate clinic in venereal disease.

10. That such individuals as may consult public health agencies relative to receiving treatment be referred to physicians taking advantage of post-graduate educational opportunities.

11. That the departments of health of Lansing and Ingham counties purchase and maintain an active file for control of infected cases and in addition that these departments of health obtain such necessary standard equipment as is advocated and approved by the United States Public Health Service.

12. That sero-diagnostic testing of patients be continued within the capacity and ability of the physician to do so.

13. That routine sero-diagnosis be carried out on all pregnant women.

14. That the essence of this report be mailed to all druggists in Ingham County requesting their coöperation in the eradication of counter-prescribing and self-treatment.

15. That each individual physician report all cases of genito-infectious disease at the time of diagnosis; when treatment has lapsed; and at the time of cure.

16. That the standard treatment approved and adopted by the State Committee on Syphilis Control be accepted within this community.

17. That copies of these recommendations as may be pertinent to the Department of Health be forwarded to the officers of the Department of Health, to the Board of Health, members of the City Council, the Board of Supervisors of Ingham County, and the mayor of the city of Lansing.

18. That the Sub-committee on Venereal Disease Control make such arrangements with public officers as may be possible for the remuneration to the individual physician for the treatment of venereal disease cases in the low-income bracket.

* * *

These recommendations were adopted at a special meeting of the Ingham County Medical Society on May 24, 1938.

PREVENTIVE MEDICINE AND PUBLIC HEALTH COMMITTEE, INGHAM COUNTY MEDICAL SOCIETY: O. H. Bruegel, Chairman, R. S. Breakey, C. Bradford, Frank Stiles, George Stucky, John Wellman, Harold Wiley, E. R. Van der Slice.

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DISCUSSION OF PAPERS BY DR. A. J. ASELMEYER AND LIDA J. USILTON, DR. HARTHER L. KEIM AND DR. R. S. BREAKEY

DR. HENRY COOK: I wish to congratulate the Ingham County Medical Society upon its efforts in this one field of preventive medicine. I think that all of us who are connected with organized medicine realize the interest that is certain in our group and also somewhat of the reactions that take place in the minds of other men who are not quite so active in the field of preventive medicine. Sometimes these discussions become rather irksome and we sometimes ask the question, "What is it all about, and where are we going?" Personally, I feel that we are, as a profession, more or less upon the spot to take an interest. There never was a time when the public was demanding so much of the medical profession in their health problems as they are today, and I feel that the efforts which we put forth are going to mold more or less the future course of the practice of medicine. I believe that the example which you have set for the profession in other parts of the state stands out above any other effort of any other society, especially in syphilis. Other counties are taking up the problem of syphilis as the result of the work which you are doing and the work done by the Preventive Medicine Committee of the State Medical Society. We shouldn't feel that syphilis is the last thing we are going to tackle. I believe it is our job to keep in step with other organizations such as the United States Public Health Service. We should support its activities in this field of public health medicine for two reasons. In the first place, it will help to make their efforts much more successful and certainly it will place our profession squarely before the public as a group of public servants willing to meet the responsibility. There have been many difficulties and many misunderstandings in the past upon the parts of both the public officials and the profession in understanding the relationships with each other. We are fortunate today to have a State Health Commissioner who wishes to carry our work on a strictly ethical basis. With the enthusiasm as evidenced by your County Society, I hope for a good future for the practice of medicine in this state if we meet our responsibility, which I have every confidence we will do.

DR. LOREN SHAFFER, chairman of the State Committee on Syphilis Control:

As chairman of the State Committee on Syphilis Control, I can say that we of the committee are here to learn of the things you have done. If our program is to succeed it will be necessary to have just such leadership as you have developed in setting up a program. There are many things that will be necessary to keep the control of syphilis and venereal disease in the hands of the physicians, where it belongs. It is this type of effort which will do it. I think we in Michigan are in an unusual position as far as being able to set an example to the rest of the country in control of preventable diseases, including syphilis, through the practicing physician instead of clinics and health departments. I am sure our Health Commissioner will approve and express much better than I am able to, that same idea. The problem of syphilis control, however, is not necessarily an easy one. It isn't over by the excellent work you have already done. You have made the start; I hope that you'll be able to continue it. You have found your basis, which is the first step in any syphilis control program. The next step is to arrange adequate treatment for those cases, and there again we will sit, possibly at your feet, and watch your future developments in this field. There can be many things said on this particular phase. I think you are going to hear enough about syphilis later tonight. However, Doctor Parran has summarized the whole problem of syphilis control roughly into two parts: finding and treating these patients. Unfortunately, such a survey such as you have carried out will fail of finding those cases of syphilis that are necessary to find, to control this disease, and those are the cases of early syphilis. It is estimated, and I think the estimate is high, that only half of our cases of early syphilis ever report to a physician for diagnosis or treatment in the early stage, when they are infectious and treatment is urgently indicated. Looking over our own statistics in a large group of cases, I was surprised to find that out of 6,000 cases of syphilis only from 100 to 200 of those cases were diagnosed as early syphilis. What happens to these cases? Why don't they reach the doctor? This is principally due to the paucity of early symptoms: the weakness of drug store prescribing, et cetera; the lack of education of the laity; failure on our part in searching for sources and contacts of those early cases that do reach our office for diagnosis. We'll hear more tonight about treatment of early syphilis, which is such an important part of our program. It is conservatively estimated that only 20 per cent of our early cases of syphilis which report to our offices ever take such treatment to secure an arrest of the disease or to control infectiousness. It is a big problem in syphilis control when only one-half of early cases are diagnosed, and less than one-fifth of one-half that are diagnosed receive adequate treatment. Let's carry on our program even further. Prevention of congenital syphilis should be a rather easy problem if we can utilize the blood test in pregnancy. I wish to compliment you for the outstanding work you are doing in syphilis control and the example you are setting.

* * *

DR. DONALD GUDAKUNST, Commissioner of Health for Michigan: The control of syphilis, while it is a tremendously important public health problem, is not a problem that can be handled by the Health Department or by the Public Health Departments. It is a thing which must be handled and controlled by the public itself. It must be treated and handled as other diseases are handled. In fact, this County Medical Society has undertaken the first major step, the interest of the public and interest of the physician in this disease means that we have the battle at least nine-tenths won. The rest of it is going to be comparatively easy. When we can get the medical profession working on it and the public interest in it, then your Public Health Department has little else to do with it save a little help here and there.

* * *

DR. GEORGE H. BELOTE, Associate Professor of Dermatology, University of Michigan: I'm truly very sorry that I had not had this material for study. I came for what I could learn. I wanted to come to learn what was going on and if the material would be applicable to other communities and what could be done about it. Doctor Aselmyer has presented a large amount of material. It would be perfectly foolish for me to attempt to draw conclusions from what I have been able to gather. If I did not misinterpret, I find that your percentage of positive tests as determined by routine testing is somewhat less than we find in routine serologic tests at the University Hospital. The routine blood test has been part of the examination of every patient registering at the University Hospital for years and we find in that group which represents a little different group than you are accustomed to deal with in your private offices, this group might be comparable to the lower two-thirds of the patients that you deal with in your private offices, we find that if we consider both weakly and strongly positive tests we have 5 per cent of positives. Here you have 2.4 per cent. If we consider only the strongly positive tests we find approximately 4 per cent of routine positives. I do not think the question of false positives and false negatives is of great importance although we do realize that there are considerable numbers of both. We're finding more and more that certain conditions, particularly with increased sensitivity of serologic tests, are giving us false positives. Serologic tests which are positive at the present time would show, if they were taken with the sensitivity of the test of twenty years ago, perhaps 65 per cent less positives.

One point would deserve a little more study. Doctor Aselmeyer pointed out that approximately 237 more positives were found in the survey period than had been found in a like period before. I would like to know which were actually actively infectious dangerous cases and how many were among pregnant women. If they were actually actively infectious cases this would be of great importance because those cases are the ones which we expect to disseminate infection. I want to go further into the question of inadequate treatment. When you give inadequate treatment for any reason whether through your own failure or through the fault of the patient, you have not only failed to protect the patient and contacts, you have actually made that patient worse than he otherwise would be. Studies have shown that the ultimate outcome in cases inadequately treated ultimately are worse than those left alone. It does not take into consideration one fact which may be important from the standpoint of contacts. Even with inadequate treatment you may protect a certain number of contacts for a certain period of time and from that standpoint any treatment is important. On the other hand, I repeat, statistics and studies have shown that the patient actually ultimately is worse off than had he been left entirely alone and without treatment.

There are a great many other points that could be taken up here. I think it is of a good deal of importance and feel that the Society is to be congratulated and hope that the study may be carried on.

A SURVEY OF SYPHILIS IN OAKLAND COUNTY FOR 1937*

The Committee on Syphilis of the Oakland County Medical Society
HAROLD R. ROEHM, M.D., Chairman; P. V. WAGLEY, M.D.; JOHN D. MONROE, M.D., and E. E. HAMMONDS, M.D.

A survey of syphilis in Oakland County has been undertaken and completed by the Committee on Syphilis of the Oakland County Medical Society, at the direction and expense of the Society.

The method of assembling the data was as follows: A questionnaire patterned after that used by the Venereal Disease Division of the United States Public Health Service was prepared and mailed to every Doctor of Medicine, osteopath, and chiropractor in practice in Oakland County. The questionnaire requested the following information: The age, sex, color, clinical diagnosis, blood test and treatment in every case of syphilis treated by the physician in the year 1937. Each physician who failed to reply was recircularized, and those who then failed to reply were telephoned.

There are at the time of writing 157 doctors of medicine, twenty-five osteopaths and eighteen chiropractors in active practice in Oakland County. Reports have not been received from five of these, so that this report is based on the replies from 195, or 97.5 per cent, of the physicians in the county.

Of the 152 doctors of medicine who returned a report, eighty-five (55.19 per cent) have one or more cases of syphilis under treatment; five (20 per cent) of the osteopaths have one or more cases under treatment; and no cases are being treated by chiropractors.

Treatment of syphilis in the county is obtainable from two sources, the private physician and the Oakland County Health Department. In 1937, 409 cases of syphilis were treated by private physicians, and 292 by the County Health Department. Twenty-one patients were seen but refused treatment, making a total of 722 known cases of syphilis in Oakland County. Of these patients 692 were receiving treatment, 43.36 per cent from the County Health Department, and 56.64 per cent from private physicians in 1937. Of these cases, thirteen patients also had gonorrhea. Four hundred and fifty-five of the 722 cases (61.49 per cent) were first reported in 1937. If the population of the county is conservatively estimated at 250,000, and if the lowest average figure of incidence of syphilis in industrial populations found by surveys elsewhere, or 4 per cent, is allowed, we would expect to find in Oakland County approximately 10,000 cases. As we have found only 722 known cases, of which 692 were under treatment in 1937, it would appear that over 90 per cent of the expected syphilitic population of the county either has not been diagnosed or has been diagnosed and is not receiving treatment, or both.

The 722 known syphilitic patients were classified as follows:

Prenatal	16	2.22%
Early	144	19.94%
Latent	370	51.11%
Late	165	22.86%
Congenital	27	3.74%
	722	99.87%

The prenatal cases are defined here as pregnant women, the early cases those of primary and secondary syphilis, and among these are reported three cases of chancre with dark field examinations. The latent cases are asymptomatic, the congenital cases are defined as those which are the result of intra-uterine infection with snuffles, rhagades, desquamation, Hutchinsonian teeth, corneal ulcers, saddle noses, joint effusions and other stigmata of so-called congenital lues. The late cases include asymptomatic neurosyphilis, periostitis, gumma, taboparesis, general paralysis, central nervous system lues, and cardiovascular syphilis.

Of the 722 cases, 109 (15.09 per cent) were negroes, and 613 (84.91 per cent) white. 349 were females and 373 males.

The average age of acquiring syphilis as determined by averaging the early cases was 27+ years.

The treatment that these syphilitic patients are receiving has been found by the committee to be adequate in the majority of the cases except in duration. The county is

*Read at the meeting of the Oakland County Medical Society, April 13, 1938.

limited in its treatment of syphilis of the central nervous system by lack of equipment and personnel for fever therapy. The only such treatment available is the malarial therapy at the Pontiac State Hospital, where the work is handicapped by the over-crowded condition of the hospital and limited to state patients.

Treatment is not being given to twenty-one known syphilitic patients. Since these patients are not in an infectious stage of the disease, they cannot be quarantined or followed up, as there is no legal provision for such procedures. As long as a syphilitic is not infectious, there is at present no method by which treatment can be forced on such a patient.

Free drugs for treatment of syphilis are now available at the City and County Health Departments for the treatment of individuals unable to pay for such drugs.

Summary

At the time of this survey there were seven hundred and twenty-two known cases of syphilis in various stages in Oakland County.

Four hundred and nine of these are under treatment by private physicians, and 292 by the County Health Department. Twenty-one cases refused treatment.

The treatment these cases are receiving appears adequate for the most part except for the treatment of syphilis of the central nervous system.

Conclusions

1. Approximately 90 per cent of the cases of syphilis of all types in this county are not being diagnosed or treated if the lowest average per cent of incidence of syphilis for an industrial population is accepted as reasonable for Oakland County.

2. The reports of only sixteen cases of prenatal syphilis indicate that not enough blood tests have been done on pregnant women. A survey of the American Social Hygiene Association in coöperation with the U. S. Public Health Service in 1935 showed that approximately 3 per cent of all women of child-bearing age are syphilitic.

3. It follows that the report of twenty-seven cases of congenital syphilis indicates that an insufficient number of blood tests is being done with this diagnosis in mind. A coöperative clinical group in 1934 found in a study of 431 patients that only 57 per cent of the infants born of syphilitic women with positive Wassermann reactions escaped syphilis as compared with 81 per cent of infants born of syphilitic mothers with negative Wassermann reactions.

4. The treatment of syphilis in Oakland County is adequate as far as it goes, and the doctors of medicine treating syphilis appear to be well informed. There is, however, scant provision for the treatment of central nervous system syphilis.

5. With the present statistical setup in the county it is impossible to give with any absolute accuracy the actual number of cases of syphilis present, the incidence of syphilis, in any one year, and the final results either with or without treatment.

6. The recent public educational campaign has brought out many old cases of syphilis for treatment, and the continuance of this campaign will bring out more.

7. There is a necessity for a comprehensive review of the diagnosis of syphilis in all its stages to be presented to the physicians of the county so that the presence of syphilis may be suspected in any patient presenting himself for treatment of any complaint whatever.

8. In the face of the low apparent incidence of syphilis as shown by the reports of only seven hundred and one cases under treatment in 1937, it is obvious that blood tests should be done on more patients than are done at the present time.

9. Case finding, adequate treatment and follow-up, and the prevention of new cases, through prenatal examination and registration of cases coming in from outside the county are the prime requisites in the control and eradication of syphilis.

Recommendations of Committee

1. The diagnosis of syphilis cannot be made on one positive blood test in the absence of clinical evidence. Repeated tests should be made preferably by separate laboratories at the present time.

2. The Society should support any legislation leading to the testing for syphilis of all pregnant women.

3. The Syphilis Committee of the County Medical Society should be made a standing committee with the following purposes.

a. The approval for release of all edu-

cational material in the public campaign to control syphilis.

b. The selection for and determination of special treatment for refractive indigent cases of syphilis which fail to respond to routine treatment.

c. An annual survey of the county to determine morbidity of syphilis and the efficacy of the existing methods of treatment.

4. The standing Syphilis Committee should contain among its members the Chief of Staff of the Pontiac State Hospital, the health commissioner of the county and of the city of Pontiac, and members of the County Medical Society familiar with and interested in the diagnosis and treatment of syphilis.

5. The Society should support any movement which would result in finding any cases of syphilis among

Public and private transportation employes
Municipal employees
Domestic servants
All food handlers
Hotel and restaurant employees
Barber and beauty parlor employees
Staffs of all general and special hospitals
Patients attending all public dispensaries and clinics
Applicants for children's boarding home licenses
All children adopted from orphanages
All industrial employees

6. The Society should support any legislation to the end that a legal control be given enabling adequate following up of cases until sufficient treatment has been given.

7. Since there will probably be available county, state or federal funds to recompense physicians who are interested in the treatment of indigent syphilitics, such physicians should indicate their qualifications to the committee and be listed so as to be available.

8. A carefully planned continuous program of public information and education participated in by all community agencies should be arranged in conjunction with the State Medical Society.

9. Physicians should accept the treatment of syphilis as their duty and charge according to the patients' means, since free drugs are now available.

10. Since education and industrial pressure, the marriage law and free drugs are bringing out many formerly untreated cases for treatment, and since at present our facilities are limited, legislation to force compulsory blood testing in general at this time may not be advisable or necessary.

11. This Society should continue to see that its membership is adequately informed as to the diagnosis and treatment of syphilis in all its stages, so that the members may competently discharge their duties as guardians of the public health.

12. Since there are at present no facilities for fever therapy of C.N.S. syphilis in the county except for malaria treatment at the State Hospital, where the facilities are limited, it seems advisable to recommend the installation of such equipment in our hospitals and the training of the personnel necessary to use such methods.

13. It is suggested that an index system be installed by the County Board of Health in conjunction with the State Board of Health to build up an accurate morbidity and treatment register free from duplicates.

14. The Society should support industry in the blood testing of all workers so that such workers may themselves benefit by treatment in their general welfare, as well as in the reduced hazard of industrial accidents.

15. It is extremely important that employers be advised that syphilis in an employee is not a cause for his discharge from employment, provided he is receiving adequate treatment. The employee must understand that he can receive adequate treatment and continue his regular work without hindrance, but, if untreated, he will sooner or later become incompetent.

16. The committee recommends that a centralized, dependable serological laboratory be established by the county, where the most modern serological methods of diagnosis now in use will be available under the direction of a competent serologist.

17. Since there are apparently about nine thousand syphilitics undiagnosed or diagnosed and untreated, or both, in Oakland County, physicians are strongly urged to take routine blood tests for syphilis on all patients.

SIX MONTHS OF OCCUPATIONAL DISEASE REPORTING

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The Occupational Disease Reporting Law (Act 210, P.A., 1937) is now six months old. During those six months, reporting has started and the initial data are now available for tabulation. Of all the reports, 56.5 per cent came from Detroit, due probably to the special efforts of the Wayne County Medical Society and the Detroit Dermatological Society to have their members well acquainted with the act and to report all cases. Occupational disease report forms were sent to approximately 5,400 physicians, yet reports have been received from only 114 or approximately two per cent. This indicates that efforts to discover or report occupational diseases are not being made by a large number of the profession. It is recognized, of course, that many physicians will never see an occupational disease case, but experience of other states would indicate that reports should come from more than five per cent of the physicians in the state.

Table I indicates the geographical distribution of the reports received and the number of physicians in those counties who have made the reports. It will be noted that no reports have been received from such industrial counties as Bay, Gratiot, Macomb, Midland, Monroe, and St. Joseph, and that in many of the other so-called industrial counties only one or two reports have been received. Where more than just a few reports have come in, it is due entirely to the reporting of a large number of cases from plants employing a full-time plant physician. Most of the reports in Genesee, Kent and Saginaw Counties come from one or two industrial plants maintaining a medical department. In Detroit this is true to a somewhat lesser degree.

Table II shows the distribution of cases according to diagnosis. It is quite evident from this table that physicians are being guided largely by the schedule of diseases made compensable by Act 61, P.A. 1937. Only three causes of occupational disease not specified in the schedule of the Workmen's Compensation Law have been reported. Dermatitis constitutes the largest single cause, 28.7 per cent of all cases. Experience of other states, where reporting has been required for some time, indicates that about 66 per cent of all reported cases are dermatitis.

Table III indicates the causative agent for the cases of dermatitis which have been reported.

TABLE I. DISTRIBUTION OF OCCUPATIONAL DISEASES BY COUNTIES AND THE NUMBER OF PHYSICIANS REPORTING IN THE COUNTIES

County	Total Cases Reported	No. of Physicians Reporting
Allegan	1	1
Berrien	1	1
Calhoun	5	3
Cheboygan	1	1
Dickinson	4	2
Genesee	22	5
Ingham	1	1
Iron	1	1
Isabella	1	1
Jackson	1	1
Kalamazoo	2	2
Kent	31	9
Lapeer	2	1
Lenawee	5	3
Manistee	1	1
Marquette	1	1
Montcalm	1	1
Muskegon	8	5
Oakland	11	3
Ottawa	1	1
Saginaw	29	6
Shiawassee	3	2
St. Clair	10	2
Van Buren	3	2
Washtenaw	1	1
Wayne (exclusive of Detroit)	48	15
Detroit	268	42
Total—26 counties	463	114

The number of cases of lead poisoning appears unusual, but further analysis of these reports shows that practically all cases were reported from one source.

Hernia apparently presents a problem to plant physicians, inasmuch as it is compensable both as an accident and as an occupational injury. Many of the cases have been "discovered" through introduction of periodic and pre-employment examinations. As time goes on this item should show a material decrease. Similarly, the items for silicosis and pneumoconiosis should decline

TABLE II. DISTRIBUTION OF REPORTED OCCUPATIONAL DISEASES BY CAUSES

(Number in parenthesis is item number in schedule of Compensation Act)

County	(2) Lead	(12) Dope	(13) Formaldehyde	(14) Chrome	(18) Miner's Diseases	(22) Carbon Monoxide	(24) Petroleum Products	(25) Blisters & Abrasions	(26) Bursitis & Synovitis	(27) Dermatitis	(28) Hernia	(29) Phthisis	(30) Silicosis	(31) Pneumoconiosis	Myositis	Paronychia
Allegan			1													
Berrien													1			
Calhoun										4			1			
Cheboygan				1												
Dickinson													4			
Genesee	1							1	1	19						
Ingham							1									
Iron										1						
Isabella										1						
Jackson										1						
Kalamazoo						1								1		
Kent	1							12		10	1		3	4		
Lapeer										2						
Lenawee						1				4						
Manistee										1						
Marquette													1			
Montcalm										1						
Muskegon								1		2			5			
Oakland	1								5	3	1		1			
Ottawa										1						
Saginaw				1	1			13	4	9				1		
Shiawassee										2	1					
St. Clair										1			9			
Van Buren						1				1				1		
Washtenaw										1						
Wayne	1			1		2			1	11	8		18	6		
Detroit	68	1				4		1	15	59	42	3	59	8	7	1
Total	72	1	1	3	1	9	1	28	26	134	53	3	102	21	7	1

after all the cases, found for the first time with the introduction of employment examinations, have been reported.

Among the reports received, a certain number failed to fall in the schedule classification, and, from either lack of information or from the information given in the report, were not considered as true occupational disease reports. Table IV lists this group according to the physician's diagnosis.

The one item over which the most discussion has occurred is friction burns. Some physicians claim that the burn is due to constant friction over a period of time. Some feel that it must be reported because in the schedule of compensable diseases it is made compensable under item 25: "Disability arising from blisters or abrasions, caused by any process involving continuous friction, rubbing or vibration causing blisters or abrasions."

Regardless of what arguments may be raised, the act provides that occupational diseases shall be reported to the Commis-

TABLE III. OCCUPATION OR CAUSATIVE AGENT OF REPORTED CASES OF DERMATITIS

Acid	3
Bakers and confectioners	4
Brass	1
Buffing	1
Chemicals specified	6
Cement	1
Degreasing	1
Dyes and dyed goods	6
Foodstuff	3
Ink	3
Leather	1
Metal	12
Oil, grease, cutting compounds	56
Paint, lacquer, enamel, varnish, thinner	5
Petroleum products	4
Plating	2
Rubber compounds	2
Soap and cleaning compounds	14
Soy bean	1
Sugar making	1
Welding	1
Wood	6

TABLE IV. OCCUPATIONAL DISEASE REPORTS WHICH FOR SOME REASON GIVEN ON REPORT OR FOR LACK OF INFORMATION WERE NOT ACCEPTED AS BEING TRUE OCCUPATIONAL DISEASE REPORTS

Arthritis	1
Boils	2
Bronchitis	1
Burns, chemical	7
Burns, friction	32
Burns, oil, infected	1
Callus	1
Fracture	1
Furuncle	4
Herpes zoster	1
Hernia	3
Inflammation and infection	4
Influenza	1
Laceration	1
Lumbago and lumbosacral strain	4
Methane poisoning	1
Myalgia	1
Neuritis, ulnar	2
Pain	1
Poison ivy	1
Pustule	1
Sacro-iliac strain	6
Sinus	1
Sprain and strain	6
Soreness	1
Syphilis	1
Tender thumb	1
Tuberculosis	3

sioner of Health, and further specifies that:

"An occupational disease, for the purpose of this statute, is an illness of the body which has the following characteristics:

"1. It arises out of and in the course of the patient's occupation.

"2. It is caused by a frequently repeated or a continuous exposure to a substance or to a specific industrial practice which is hazardous and which has continued over an extended period of time.

"3. It presents symptoms characteristic of an occupational disease which is known to have resulted in other cases from the same type of specific exposure.

"4. It is not the result of ordinary wear and tear of industrial occupation or the general effect of employment or the kind of illness that results from contacts or activities in life outside of the patient's occupational pursuits."

In order to make reporting as uniform as possible and prevent its becoming burdensome, the following suggestions are therefore made: All disabilities arising out of occupation, whether they are on the schedule or not, whether disabling or not, whether causing lost time or not, should be reported, *provided* the disability will meet the definition of an occupational disease as defined in the above act.

DECOMPRESSION OF THE SMALL BOWEL BY INTESTINAL TUBE DRAINAGE AT SITE OF OBSTRUCTION*

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Any discussion which refers to intestinal obstruction must take cognizance of the vast amount of literature on this subject. A study of the contributions to this subject for the past sixty years indicates the small progress made in the treatment of this condition. Treves[7] indicated in 1884 that the current mortality from intestinal obstruction was approximately 60 to 70 per cent. Schramm[6] indicated that some progress had been made in the period from 1873 to 1883, when his statistics showed a mortality for cases operated prior to the former date of 73 per cent, while in those cases collected from 1873 to 1880, the mortality was 58 per cent. This, of course, may illustrate nothing more than the expected variation in series or it may mean improvement in operative procedure. Compared to the sta-

*Read before the seventy-second annual meeting of the Michigan State Medical Society in Grand Rapids, September, 1937.

tistics of today, the decrease in mortality figures is none too heartening. Miller[4] reported a mortality of 61 per cent in 1929, McIver[3] of 44 per cent in 1932.

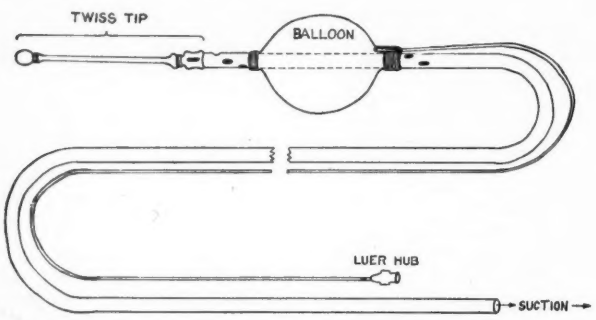

Fig. 1. Diagram of tube for small intestine intubation.

Experimental work on the nature of the cause of death in intestinal obstruction has progressed ahead of the clinical advances in this subject. The rôle of the two cardinal features of intestinal obstruction, distention, and loss of fluid and salt are better understood today. Convincing data regarding the rôle of these two features has been presented by Hartwell and Hoguet,[1] Herrin and Meek[2] and others. One hears very little discussion today concerning the rôle of the absorption of toxic materials in intestinal obstruction, and while the possibility of toxemia playing an important rôle in the cause of death has not been ruled out completely by experimental studies, there is sufficient evidence at hand to point out that death may result from intestinal obstruction without absorption of toxic materials from the obstructed gut.

Relief of the cardinal features of intestinal obstruction, distention and loss of fluid and salt therefore are of primary importance in the treatment of this condition. Corrective operation during the period of acute obstruction is always hazardous and usually difficult. Relief of the distention has been afforded frequently by the expediency of an enterostomy just above the point of obstruction. This procedure is not without danger to the patient ill from intestinal obstruction, but in cases of mechanical block does allow decompression of the dilated gut. Since the popularization of gastric or duodenal siphonage by Wangensteen and his associates there has been a definite decrease in the number of enterostomies performed. It is frequently possible to tide the patient over his acute illness by the use of gastric or duodenal siphonage and adequate intravenous fluids. Wangensteen has pointed out that this form of treatment does not mean that there is no place for enterostomy in the treatment of intestinal obstruction, since an enterostomy has the advantage of allowing the patient to be fed, a definite deficiency in treatment by siphonage. There are those who decry the use of suction drainage on the basis that it delays operative procedure and operation if performed, must be performed early for best results. Just as in the case of ruptured peptic ulcer, the mortality increases with delay. In those cases where drainage of the upper reaches of the intestine does not decompress the distended loop of bowel above the obstruction, siphonage of the material from the stomach or duodenum may cause delay in proper operative intervention if too much dependence is placed on it.

Several years ago it occurred to us that a combination of the features of enterostomy and duodenal siphonage would afford the ideal in treatment of small bowel obstruction. If it were possible rapidly to pass the drainage tube to the point of obstruction, this objective might be obtained. Tubes have been passed far into the intestinal tract but prior to the work of Abbott and Miller, the passage of the tube was quite time-consuming. Abbott and Miller, by using an inflatable balloon on the end of the intestinal tube, were able to pass the tube to the lower ileum within 6 hours. The use of such a tube would permit actual drainage of the distended loop as effectively as would an enterostomy and should likewise have the added feature that the entire gut above the obstruction would be swept clean of fluid and gas as the tube progressed.

Three years ago, Dr. Wm. O. Abbott and myself prepared to try this method of treatment in selected cases of intestinal obstruction and found that the tube could be passed far down the small intestine even though obstruction was present.

In this communication, I would like to discuss the indications, contraindications and procedure of this type of treatment. The tube for use is similar to that described by Abbott and Miller[5] and consists of a 16 to 18 gauge rubber tube, 10-12 feet in length at the lower end of which is attached a balloon (Fig. 1). In order to inflate the

balloon a fine stiff rubber tubing extends the full length of the larger tube and is attached to the balloon. Several holes are made in the lower end of the large tube to allow free entrance of fluid. The procedure for making these tubes is quite simple. The tube with the balloon empty is passed through the nose and slowly into the duodenum as is any ordinary duodenal tube. We have found the use of the Twiss tip of advantage in getting the tube into the duodenum. After the tube is well into the duodenum about 10 cubic centemeters of air is injected into the balloon to give bulk. The tube is then passed slowly further until about a foot more of tubing is passed. The balloon is then inflated so that it has a volume of at least 30 c.c. The tube can then pass more readily downward propelled by peristalsis as the gut below it is decompressed. In cases where speed of insertion is required this procedure can be carried out under fluoroscopic control. This is, however, usually not necessary. During the passage of the tube, it is quite necessary to keep the tube from blocking by constant irrigation, as the material removed is usually quite thick. After the tube has decompressed the bowel completely, the patient is allowed to eat a low residue diet, especially one lacking in fiber. As a rule the tube requires only occasional irrigation after it has reached its objective of primarily decompressing the bowel. Fluids and salt lost through the tube must be replaced, and since these patients are usually dehydrated, they must receive additional fluid during the early part of their treatment.

Possibly the best way to discuss the indications and contraindications relative to this type of treatment is to present cases which illustrate and answer some of the fears which were prominent in our minds at the beginning of our work. The most prominent of these was that we might attempt to treat cases in which there was non-viable gut. We have been careful therefore to exclude all cases in which there were strangulated herniæ. It is probable that cases of internal strangulation might be overlooked, but usually careful examination and history suggest their presence by the relation of onset of pain to distention, and the tenderness of the abdomen. Small Richters herniæ are likewise liable to be overlooked. We have in our series one such case of an 81 year old obese woman who had intestinal obstruction of two days duration. She had a diaphragmatic hernia and it was impossible to pass the tube from the thoracic portion of her stomach. Nevertheless, her abdomen became softer and her general condition improved. She had several bowel movements on two successive days. She however became suddenly worse, her abdomen became tender, and again distended, and she died within 8 hours after the re-occurrence of her symptoms. At postmortem the diaphragmatic hernia was found not to be causing her obstruction as supposed, but there was present peritonitis resulting from a small Richters hernia at the left internal femoral opening. This was unquestionably a case of mistaken diagnosis; whether operation would have changed the result is beside the point.

The subject of the rarer forms of obstruction with strangulation which may not be diagnosed permits of some reassurance from a study of statistics on intestinal obstruction.

Intussusception, volvulous, internal herniæ, Meckel's diverticulum and congenital anomalies, caused in McIvers[3] group of cases but 11.1 per cent of the total number of cases or 19.1 per cent of all cases except external herniæ. In this latter condition there should be little trouble with the diagnosis. The mortality in the group, excepting external herniæ, was 44 per cent. A comparison of the total possibility of error in diagnosis to the mortality figures indicate that should the non-operative procedure carry with it an appreciable decrease in the death rate in the cases for which the procedure is intended there is a good possibility of decreasing the total mortality in cases of intestinal obstruction. At present our mortality of cases which we have decompressed with the tube is approximately 10 per cent. We have not, of course, attempted the use of the tube in cases of strangulation when diagnosed. Cases of strangulation obstruction should not have conservative treatment except possibly for mesenteric thrombosis. Changes in the color of the gut so frequently seen in simple acute intestinal obstruction without interference with the mesenteric blood supply is the result of distention and has caused us no concern since, with the release of the

tension within the gut, the blood supply should be adequate. Two of the cases in which we failed were individuals who died, one within two hours, the other within six hours after being seen. The fourth case was operated upon, an enterostomy being done, despite the presence of an unrecognized peritonitis. The reasoning from statistics as I have attempted in the above cannot be used as a criterion for the success of treatment by the long tube, but it does afford assurance to permit us to carry on our studies.

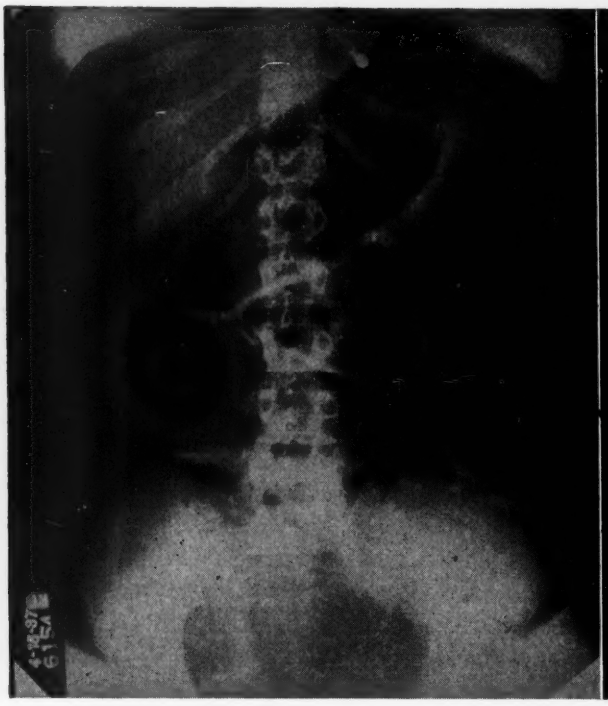

Fig. 2. Marked distention of small bowel. Peristalsis visible on admission. Duodenal suction drainage not effective.

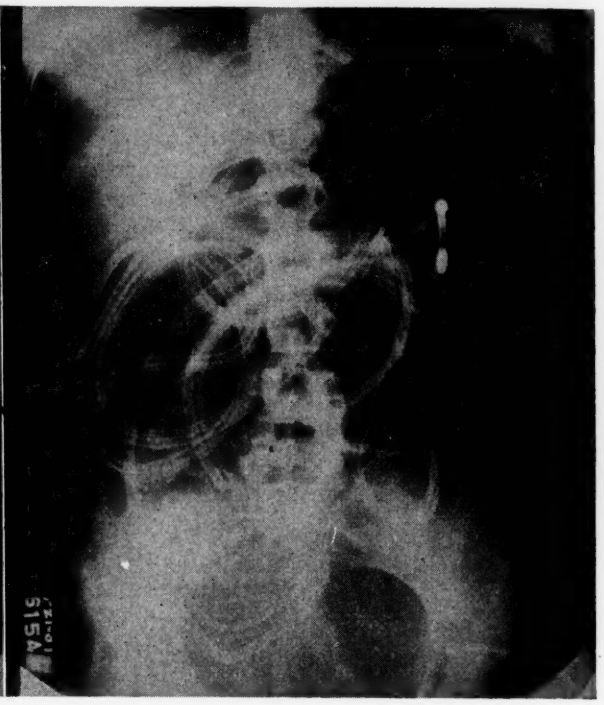

Fig. 3. Decompression of small bowel complete with tip of tube in lower ileum just above point of obstruction.

The next fear which confronted us was that we were relieving the immediate danger, but were not correcting the cause of the obstruction. This is undoubtedly true in many instances, and we have operated but few cases of our group. One had an enterostomy performed which I have mentioned; another was a man with complete obstruction who was never in condition for operation until almost a month after therapy was started, and who was finally operated and the obstruction relieved. This case will be discussed later. One of our cases has been relieved from his obstructive symptoms four times and has now been free of symptoms for four months. I suspect that he may ultimately have to be operated, but I feel sure that time has released more adhesions than have surgeons. I am a bit unwilling to perform his fourth abdominal operation so long as I can follow him and keep him in good health by intubation.

One other problem which will always confront us is that perhaps duodenal siphonage would have done just as well. Duodenal siphonage can remove only material forced up from below and there must needs be tension developed to accomplish a reversal of the flow (Figs. 2 and 3).

The following case as well as several others in our series developed obstruction during duodenal siphonage. Two cases are worthy of citation in this regard.

K. A. was a forty-year-old Armenian who had an appendectomy with drainage in 1931. He entered the hospital with an obstruction in a large ventral hernia and was operated. A portion of the ileum was resected. There was considerable spill at the time of operation, and a drain was left in the wound. He was placed on duodenal siphonage but on the fifteenth day, his temperature increased and he became distended. Examination through the drainage tract revealed retroperitoneal cellulitis. He was kept on siphonage drainage with adequate intravenous fluids, but his distention and general symptoms became worse. His distention disappeared with long tube drainage and he was relieved of his obstructive symptoms.

The other case which illustrates this point was D. P., aged thirty-one, a filling station attendant

who was shot through the stomach by a bandit. Prior to this catastrophe, he had been losing weight and had had all his teeth removed because of ill health, one and a half weeks before. His weight on admission was less than 100 pounds. At exploration a large through and through bulet wound in his stomach was repaired and a branch of the colic artery which was severed was ligated. There was a large quantity of blood in the peritoneal cavity. In order to keep his stomach empty, continuous duodenal suction was employed. After eight stormy postoperative days it became evident that he was completely obstructed and was rapidly losing ground. A long tube was passed into his terminal ileum and his abdomen became scaphoid and he was comfortable. However, two days later his tube became blocked after relatives had supplied him with oranges to eat, and he became rapidly worse. The tube was removed and the openings found to be blocked with orange pulp. It was cleaned and reinserted. He gained strength on this therapy and after having had the tube for over three weeks with no evidence of release of his obstruction, operation was performed. The intestines were matted together but were not dilated except for about 4 inches situated about 8 inches above the ileocecal valve where the gut was firmly bound and kinked. The tube was found to be within 6 inches of the obstruction and the gut was of good color. He left the hospital twenty-three days after operation, and has since resumed his work. He is now in fair health. Decompression permitted operation in this case which would otherwise have terminated fatally.

We have likewise been successful in passing the tube through the terminal ileum in a case of postoperative paralytic ileus. The propulsion of the tube might not have been expected since peristalsis was not active. Apparently in this case the intrinsic innervation of the small gut was sufficient to carry the tube along.

G. L. was a sixty-two year old man who developed paralytic ileus after a suprapubic cystotomy. This patient was operated July 1, 1937, at which time suprapubic cystotomy for vesical calculus was done. On the same day of his operation he became markedly distended, belched large quantities of gas, and could not eat or take fluids. Wangensteen suction relieved his distention somewhat, but periodically his abdomen became quite tense. On the night of July 2, a flat plate of the abdomen showed a marked paralytic ileus, many of the loops of small bowel being three to four inches in diameter. The tube was inserted on the evening of July 9. The following morning another flat plate of the abdomen was taken and showed the tip of the tube to be just past the ligament of Treitz. The balloon was then distended and the tube passed down into the intestinal tract rapidly. He was quite relieved of his distention by early afternoon, and by the following morning his abdomen was quite flat and the patient was eating and drinking fluids. The tube was removed on the twelfth, and the patient was given proctoclysis and catharsis. He had some slight distention later which was easily controlled by catharsis and enemata and was able to eat and drink normally.

An additional advantage of the tube is that it allows a localization of the point of obstruction in many cases (Fig. 4). With the tube at the point of obstruction the danger from introduction of barium in oil is minimized. If a partial obstruction

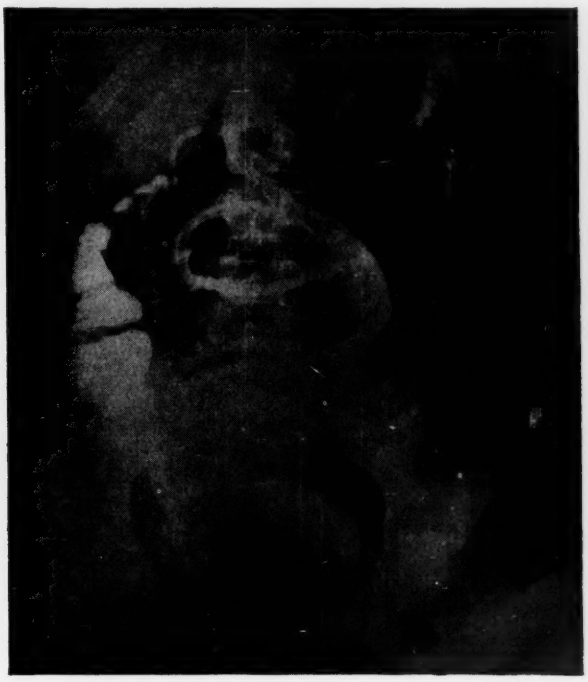

Fig. 4. Barium injected down tube outlining obstruction in lower ileum.

should become complete, the small amount of barium necessary to outline the point of obstruction may be washed out of the intestine through the tube. In the majority of our cases, this material passed readily through the intestinal tract after the distention was relieved even though the obstruction appeared complete at the beginning of therapy.

At Receiving Hospital and the Department of Surgery, Wayne University College of Medicine, a group is studying the general problem of intestinal obstruction. It is only just that I mention that I have had associated with me in this work Dr. Wm. Osler Abbott of the University of Pennsylvania, Dr. Kenning and his associates at Receiving Hospital, and have had the coöperation of an interested and alert house staff. There is seldom a period when there is not more than one case of intestinal obstruction on the wards of Receiving Hospital. Fortunately for our studies the majority of those cases were postoperative cases. It is only fair to state that relatively few were operated in Receiving Hospital, but were sent to us by the City Physicians as emergency cases.

Summary

A non-operative method for decompressing distended small intestine which combines features of suction drainage and enterostomy is presented.

Possible pitfalls arising from the use of this method in small bowel obstruction are discussed with relation to illustrative cases.

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REVIEW OF A CASE OF THROMBO-CYTOPENIC PURPURA TREATED BY SPLENECTOMY*

GEORGE T. AITKEN, M.D.

GRAND RAPIDS, MICHIGAN

Splenectomy for thrombo-cytopenic purpura is neither a new nor unusual therapeutic procedure. It is believed that this case warrants reporting, though, for two reasons: (1) There is a careful check on the patient's clinical and blood picture for one year postoperatively, and (2) the original diagnosis was a contested one.

The patient, a six-year old, white male, first came under our observation on September 26, 1933. Two years previously he had been treated at another hospital for a compound fracture of the right tibia and fibula which was complicated by an osteomyelitis, but the end-result was satisfactory. He had only to wear a short caliper brace. During one of his return visits to this other hospital for a check on his osteomyelitis, it was necessary to admit him because of frequent severe nose bleeds. His hemaglobin at this time was below 50%, and the red blood count varied between two and three and one-half millions, with a consistent decrease in the number of platelets. In August, 1932, he was discharged from this other hospital with a secondary diagnosis of thrombo-cytopenic purpura. Early in 1933 he was again admitted to the other hospital with a sore throat. At this time nasal mucous membrane hemorrhages were severe enough to necessitate several transfusions of whole blood. Three months later a detailed blood study revealed

Red blood cells	3,260,000
White blood cells	3,700
Hemoglobin (Sahli)	36%
Polymorphonuclears	52.5%
Large lymphocytes	3.0%
Small lymphocytes	34.5%
Monocytes	7.5%
Eosinophiles	2.5%

Platelets reduced. Red blood cells small, pale and round.

From this a diagnosis of aplastic anemia was made. The old diagnosis of thrombo-cytopenic purpura which was made in 1932 was refuted. A tonsillectomy and adenoidectomy was done. Transfusions, pigeon serum and snake venom were used in a supportive manner. The mucous membrane and subcutaneous hemorrhages persisted. At this time the patient was transferred to the Orthopedic Clinic at Blodgett Memorial Hospital.

From September, 1933, until June, 1935, the patient was followed in Grand Rapids. During this period it was necessary to keep him in the Convalescent Home a great portion of the time because he had chronic, intermittent hemorrhages from the nasal mucous membranes and under the skin. These hemorrhages were severe enough to necessitate transfusions varying in quantity from 250 c.c. to 500 c.c. at a time. His blood count was checked frequently and remained about as reported from the other hospital. There was a consistent reduction in platelets and at no time were ever more than 10,000 reported. The bleeding time remained prolonged, but the clotting time normal. Transfusions seemed to be only palliative, and snake venom gave no relief.

In June, 1935, the patient was again referred to the other hospital for re-examination and a review of his condition. At that time they reported his detailed blood work as follows:

Red blood cells	3,200,00
White blood cells	4,600
Hemoglobin (Sahli)	47%
Polymorphonuclear neutrophils	49.0%
Large lymphocytes	22.0%
Small lymphocytes	10.0%
Monocytes	11.0%
Eosinophils	6.0%
Basophils	2.0%

Plasma cells were present. Platelets were practically absent. No basophilia of the granules of the neutrophils. Reticulocytes about 3.0%.

At this time the diagnosis of hypoplastic anemia was again advanced and splenectomy was advised against. They stated that there was not a selective decrease of the platelets, but rather a total decrease of all of the blood elements.

The patient was then returned to Grand Rapids on a régime of 1 c.c. every second day of staphylococcus toxoid No. 1 until the vial was finished, then a course of staphylococcus toxoid No. 2 triweekly. This helped somewhat, but towards the fall of 1935 the patient apparently became refractive to this medication and his chronic, intermittent nasal and subcutaneous hemorrhages recurred.

A peculiar feature of his bleeding, noticed at this time, was that it appeared to be cyclic without a constant time interval and preceded by a definite lethargy and feeling of apprehension. Those in

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charge of his care at the Convalescent Unit were able to accurately predict periods of bleeding.

In October of 1936 a complete review of this patient's findings was made and further blood studies were done. The blood picture was about as previously shown. There was still a leukopenia with a relative lymphocytosis. In the presence, however, of reticulated red blood cells and persistent hemorrhages it was felt that hypoplastic anemia could be ruled out. Clinically, the patient, now a ten-year old white male, was pale and apprehensive. The tourniquet test was positive and his clotting time was delayed. There was, however, no palpable enlargement of the spleen.

After consultation and much discussion splenectomy was decided upon. Our decision was undoubtedly influenced by the fact that the child was rapidly losing ground from a physical standpoint. His hemorrhages were more frequent and his recuperative powers were diminishing.

He was prepared for surgery by a 500 c.c. transfusion of whole blood. The usual technic was employed at the time of operation and a slightly enlarged spleen was removed. Microscopically, the spleen presented the following picture: "Sections show interstitial fibrous tissue hyperplasia, congestion, reticulo-endothelial hyperplasia, numerous eosinophils in the sinusoids. Much phagocytic activity."

Eleven days following surgery the patient received another transfusion of 300 c.c. of whole blood. His postoperative recovery was uneventful and he was discharged from the hospital to the Convalescent Unit. He was there for fifteen days, after which he was discharged to his own home to go to regular school and resume normal activity.

On May 25, 1937, he came into the clinic stating that he had bled about fifteen drops from his nose. There was a history of trauma. Observation for several days revealed no evidence of hemorrhagic tendencies, so the boy was redischarged to his own home and regular school.

A careful postoperative check of the blood picture showed an irregular increase in the number of platelets. The average of the increase was below that usually reported in literature. (See table.) Eosinophilia was marked about six weeks postoperatively. There was a steady rise in the red blood cell count and hemoglobin reading with a maintenance of the same. Clinically, the patient was much improved. He gained weight, his color returned, and his apprehension disappeared. A chronic invalid became a normal individual pursuing a normal, daily routine of living.

TABLE I

Date	RBC	Hgb.	Platelets	Bleeding time Min.	Sec.
3-10-32			10,000		
1933			10,000	4	
3-28-35	6,050,000	100%	10,000	20	
1935			10,000		
10-30-36	2,540,000	35%	Insufficient to count		
11-11-36	2,950,000	45%	Insufficient to count		
11-15-36			Insufficient to count		
11-16-36			Insufficient to count		
11-23-36	3,750,000	55%	10,000		
11-24-36	3,120,000	50%	10,000		
11-25-36	3,550,000	50%	22,000		
11-26-36	3,420,000	50%	18,000		
11-28-36	3,610,000	50%	21,000		
11-29-36	3,790,000	50%	15,000		
11-30-36	3,920,000	55%	10,000		
12- 1-36	3,970,000	45%	18,000	4	
12- 2-36	4,500,000	60%	14,000		
12- 3-36	4,600,000	60%	18,000		
12- 4-36	4,450,000	70%	18,000		
12- 5-36	4,560,000	65%	20,000		
12- 7-36	4,520,000	65%	14,000		
12-19-36	3,900,000	65%	175,000		
12-26-36	4,250,000	70%	85,000		30
1- 2-37	4,500,000	80%	60,000		30
1- 9-37	4,340,000		110,000	4	30
1-16-37	4,450,000	70%	30,000		
1-21-37	4,450,000	70%	30,000	1	30
1-23-37	5,400,000	85%	30,000		
1-30-37	5,420,000	80%	30,000	3	
2- 6-37	4,550,000	80%	35,000	6	45
2-13-37	4,940,000	85%	30,000	1	30
2-20-37	4,420,000	80%	30,000		45
2-27-37	3,650,000	70%	35,000	1	30
3- 6-37	4,260,000	80%	25,000	1	30
4-22-37	4,150,000	80%	70,000	1	20
5-22-37	5,000,000	85%	30,000		30
6-26-37	4,290,000	80%	48,000	1	
10- 7-37			75,000		

Summary

1. We present a case of chronic purpura hemorrhagica which in an acute exacerbation had a splenectomy.

2. One year's careful check on this patient reveals a clinical cure without the usual increase in the number of platelets.

3. An enlarged spleen was not demonstrated preoperatively, but after removal it was found that there was a true splenic enlargement.

4. Eosinophilia was a transitory sequelæ of splenectomy in this case.

Hypoparathyroidism: Treatment of Chronic Cases

Under carefully controlled conditions, R. H. Freyberg, R. L. Grant and M. A. Robb, Ann Arbor, Mich. (*Journal A. M. A.*, Nov. 28, 1936), measured in two patients the effect of various remedies frequently employed in the treatment of chronic postoperative parathyroid tetany. The data obtained indicate that in order to compensate most satisfactorily for the altered state of calcium and phosphorous metabolism, the intake of phosphorus should be low and the calcium intake high. This can best be accomplished by feeding a low phosphorus diet (which will also be low in calcium) and large amounts of calcium salt, other than a phosphate. The commonly employed high calcium (milk) diet is undesirable because of its high phosphorus content. A solution of calcium lactate, in amounts sufficient to provide from 1.5 to 2.5 gm. of calcium daily, is in many respects the best method of administering calcium. Vitamin D in large amounts is of definite value and should be given. Hydrochloric acid and magnesium carbonate were not beneficial. Thyroid substance should be administered, if hypothyroidism exists. Improvement in calcium and phosphorus metabolism that could be attributed definitely to thyroid medication was not observed. Although substitution therapy, consisting of the subcutaneous or intramuscular injection of parathyroid extract, is the most specific treatment, there are serious objections to the long continued use of this extract. If successful management can be accomplished without the use of parathyroid extract, it is advisable not to use it. Patients with severe chronic hypoparathyroidism can be maintained in a state of good, if not perfect, health without the use of parathyroid extract. The effectiveness of parathyroid extract when injected intravenously into a patient who had become "immune" to the extract injected subcutaneously suggests that "refractiveness" to parathyroid extract is due to a localization of destruction of the active principle at the site of its injection.

THE JOURNAL
OF THE
Michigan State Medical Society

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JULY, 1938

"Every man owes some of his time to the upbuilding of the profession to which he belongs."

—THEODORE ROOSEVELT.

EDITORIAL

EDITORS DO NOT ENDORSE

DR. Walter C. Alvarez of the Mayo Clinic certainly knows what he is talking about when he comments editorially in the *American Journal of Digestive Diseases* on the editor's problems: "One of the everyday problems of editors of medical journals is what to do with papers reporting brilliant results in the treatment of disease with some new drug." He continues, "Every student of therapeutics knows that every time a new drug catches the fancy of physicians or proves to be useful in one small field of disease, it is immediately tried out extensively for the relief of almost every known malady."

Dr. Alvarez goes on to mention the fate of quinine found helpful in malaria over a hundred years ago, which was tried out in the treatment of all other fevers. Subsequently, it was supposed to be a great tonic, but at the present, the careful physician is inclined to limit its use to the treatment of malaria. The foul smelling and foul tasting creosote, hailed as one of the fixed stars of therapeutics, particularly in the treatment of tuberculosis, has happily fallen into complete disuse. Today, sulfanilamide occupies the spot in the center of the stage. Time will doubtless deal with it as it has with other drugs whose merits have been loudly proclaimed.

The policy of THE JOURNAL of the Michigan State Medical Society has been to refrain from endorsing drugs or medicinal agents. This is all left to the council on Pharmacy and Chemistry of the American Medical Association, whose endorsation is accepted. When a contributor writes up his experience with a drug, not endorsed by the Council, he is responsible for his own comments on its use. If they are too enthusiastic, the enthusiasm should react not to his advantage.

Dr. Alvarez comments very interestingly on the editor's experience as follows:

"Often then, as an editor looks at the pile of therapeutic reports that come to his desk, his tendency is to send them back; he hates to think of padding the files of his journal with a mass of articles which are almost certain to be worse than useless later. But then he will wonder, 'Perhaps there is a grain of truth here, and I should not be denying it publication.' But, as he rereads the long article with all its case reports, he asks, 'Is all this necessary? Why couldn't the man have said simply that he tried so-and-so's new medicine in thirty cases of ulcer, and his impression was that the patient did better than they would have done on diet and Sippy powders alone?' What reams of paper this would save, and actually how often the writer's object would be better served with the short, pithy, readable report than with the long tiresome one.

"Other physicians, noting such a report, might be induced to make similar studies; they also might make short reports, favorable or unfavorable, and soon the rank and file of the medical profession would gain a good idea of what drugs are worth trying and what are not. Unfortunately, today, few men write unfavorable reports, perhaps because they assume that every paper must be a long and detailed one, and they haven't time to spend over a 'dead horse.' Actually, how helpful and simple it would be if soon after a new and popular drug was introduced, notes like this would appear: 'I tried the drug in such and such dosage in twenty cases of this and that with apparently good beginning results in some. In two cases the results seem to be fairly permanent. In several cases I had to stop administration because of abdominal pain, diarrhea, and skin eruptions, and in one case the patient promptly died with a severe leukopenia. I have decided to stop using it. Signed .....'"

INFORMING THE LAYMAN

PERHAPS there is no subject of greater interest to the average layman than that of how to maintain the best possible health, and perhaps there is none other about which such erroneous and bizarre views are held. The function of the Joint Committee on Health Education, now sixteen years old, has been to provide the need with knowledge which is accurate and simple.

Since its organization, by means of lectures, by radio and through the public press, hundreds of thousands of persons in this state have been reached and the reception has been most enthusiastic. There is, however, a great deal to be accomplished. The work continues and will never end so long as there are willing listeners and readers.

"The function of the Joint Committee," as quoted by Dr. B. R. Corbus, chairman of the recent annual meeting in Ann Arbor, "is to present to the public the fundamental facts of modern scientific medicine for the purpose of building up sound public opinion relative to the question of public and private health. It is concerned in bringing truth to the people; not in supporting nor attacking any school, sect or theory of medical practice. It will send out teachers, not advocates." The Joint Committee has been true to its ideals. Its object, namely, to inform rather than to propagandize, has been adhered to all the years of its existence.

To the initial units composing the Joint Committee on Health Education, others have been added until the committee now represents twenty-seven unit organizations.

Dr. Corbus, in his annual address emphasized the need for effectual presentation of matters of health to the school child. Any long range view is justified. The schools are the proper places to acquire habits which will be beneficial all through life. He spoke of the valuable aid by the Medical profession and of the importance of follow-up efforts by teachers where these lectures are given in schools. With this object in view, two bulletins, "The Problem Solving Approach in Health Teaching," and "Health Goals for the School Child," have been prepared. The matter has further been an integral part of the program of the various state teachers' colleges. The State Department of Health has coöperated to the extent of securing certain federal grants whereby members of the faculties of various teachers' colleges may attend the University of Michigan for a year of special training in hygiene and public health.

The Joint Committee maintains a lecture bureau, and coöperating with the Michigan State Medical Society, it has been responsible for radio programs. The committee is also in a position to furnish speakers to lay adult audiences, parent-teacher associations, noon-tide clubs and any other group which may manifest an interest in the subject.

TO CONTRIBUTORS TO MEDICAL JOURNALS

WITHIN the past few years, a number of small pocket-sized digests have come into existence and are apparently thriving. Everyone is acquainted with the *Reader's Digest,* which has been before the public for two decades. Many others might be mentioned. The fact that these publications flourish indicates a demand on the part of the reading public for short articles or digests of articles which have appeared in larger lay magazines.

A similar situation is manifesting itself in medicine. It is simply impossible for the average physician or specialist in the time at his disposal to read all that he really should in order to keep abreast of the times. This JOURNAL has endeavored to meet the situation in a small way by publishing condensed abstracts of articles appearing in the *Journal of the American Medical Association.* We would like to carry the idea farther and publish abstracts of papers presented before county societies in the state, as well as before the various specialist groups in the larger cities. The demands for space in state journals continues to be more pressing, so that editors, as a rule, have enough acceptable copy on hand to supply their pages months in advance of the date of publication. The brief article or digested article would fill the purpose and at the same time make room for a larger number of others.

There are times when a paper of monograph size is in order, particularly if the writer is an outstanding student in his particular subject. The short concise paper of a thousand to twelve hundred words, other things being equal, will be read, while the

long paper, which is set aside for later perusal, may be completely sidetracked for something else.

THE GROUP HOSPITAL INSURANCE PLAN

ONE objection to the Group Hospital Insurance plan comes from the physician whose patient may have paid for hospitalization in a hospital or member of a group of hospitals in which the doctor has no access. Should the patient insist on going to the institution where his hospital bills were paid by his insurance, which he probably would, he would be required to waive his right to his personal physician's services and the patient and physician would be separated. Or if the physician happened to be on no hospital staff, he would find the group insurance plan to interfere materially with his practice, especially where it was necessary to hospitalize his patients.

The group insurance idea would also discriminate against those physicians who conduct small hospitals, efficient in every way, but which, from their size, might not be eligible to endorsation by the council on standardization of hospitals.

Again there is a strong disposition for a person to make use of anything he has paid for. Therefore, an indisposition which would ordinarily confine him to his home for a brief time, would take him to the hospital, and, if there were many like him, hospital accommodation would be at a premium.

THE JOURNAL welcomes letters from its readers, brief and to the point, on the subject. Let us have the pros as well as the contras.

SENATOR ROYAL S. COPELAND

THE death of Senator Royal S. Copeland has removed from public life a person whom Michigan had claimed as her own, for Dr. Copeland was born and educated in this state. At one time a lecturer at the University of Michigan, he was an example of what one with specialized training may accomplish outside his chosen professional career. Throughout his political life, his acts were characterized by that independence of thought and action which marks the physician. Commenting editorially, the *New York Times* said:

> "It was Mr. Copeland's lot never to be an ally of the Government in power. First elected to the Senate in 1922, he came into that assembly in the heyday of Republican triumph following the first post-war reaction. He served through the Twenties under three Republican Administrations. When the tide turned, following the great depression, and a Democratic Administration came into power, it proved to be a Democratic Administration to which he was willing to give only an intermittent loyalty. He was even less in tune with the prevailing doctrines of his own party at the close of his long career than he was with the doctrines of the opposition when he first entered national office.
>
> "Industry, independence, a specialized knowledge in several useful fields, an inexhaustible capacity for making new acquaintanceships and a natural flair for politics are among the qualities which explain the rôle that Mr. Copeland played in New York and in the nation."

The daily press has commented adequately on his career at the time of Senator Copeland's death. We would comment only on the physician as a legislator. In Michigan, it has been a rare exception that doctors have sought political preferment. In Ontario there are, or were within the past three or four years, twelve physician members of the legislature. Doctors as a rule have not the time to devote to the affairs of state—so much the worse for the state. The physician's training and experience is such that he is able to keep both feet on the ground; he is not swayed by every transitory notion. His services would be valuable to the state and nation not only so far as health legislation is concerned but in other fields as well.

With a reputation as poor business men, doctors during their professional careers have seen business firms rise and fall by the score and still the doctors carry on. They have witnessed the obsequies of many business firms that have had their day and have ceased to be. The physician's reputation as a poor business man is undeserved. The state might therefore profit from the doctor legislator's business acumen. The service rendered the United States by the late Senator Copeland is evidence of what may be accomplished by the medically trained mind.

ABOUT LEASES

THE subject of leases, like taxation and the wolf at the door, is one of the things that is a constant reminder of the stern necessities of life to a great many of us. We have seen copies of the regulation lease for space in downtown office buildings. The impression one gets is that the company had hired a lawyer who feels it is his duty to

work in the company's interest, one hundred per cent. As a result, the average lease binds the tenant body and soul both here and hereafter, should he pass over to the great beyond before its expiration, inasmuch as his heirs are also bound by the lease.

In justice, a clause should be added in the interest of the tenant to preserve his right to life, liberty and the pursuit of happiness. We would suggest a paragraph in effect as follows: "In the event of disabling accident. or prolonged incapacitating illness, or anv condition which is commonly described in legal phraseology as an 'act of God,' that would render the professional tenant unable to carry on the occupation for which he was trained, the unexpired portion of the terms of the lease will be declared null and void and the sum due for the unexpired portion cancelled." As the phrasing now stands. should a dentist or surgeon lose the use of his right hand through accident or otherwise, he might be able to eke out an existence in some non-professional calling but under the terms of the landlord, he would be obliged to continue to pay rent on an unoccupied office. It is a matter of simple equity that the interests of the tenant should be guarded equally with those of the landlord.

As a matter of fact, however, the relations of landlord and tenant as a rule are more humane. In other words, many managements waive the exaction of the pound of flesh where it is obviously impossible for a conscientious tenant to make good. However, as intimated. a more humane phrasing of the lease would provide a saving clause for the tenant as suggested corresponding to saving clauses for the landlord which hold the tenant when events transpire over which the landlord has no control.

The effect would be to promote a happier relationship between two persons who are mutually dependent.

The Name "Michigan"

The first known use of the name "Michigan" was in connection with the lake and occurs in the Jesuit Relations of 1712 wherein Pere Marest, a Jesuit Priest, writing of his return journey from Illinois to Mackinac, says, "We sailed the length of Lake Michigan which is named on the maps Lake Illinois without any reason since there are no Illinois Indians who dwell in its vicinity." The first application of the name to land appears in the proceedings of Congress in 1804-1805 which established the Territory of Michigan. The generally accepted translation of the name is "Great Lake."

SITTING BY THE INGLE

He was sitting by the ingle,* sitting quiet and wond'ringly,
He was doon intil the cushions, doon sae snug and bonnily,*
And his slippered feet were resting on the rug sae cozily,
As he sat there by the ingle, dreaming dreams sae pleasingly.

He was meditating, lonely, thinking out a mystery,
He was reading—sometimes reading—reading very studiously,
He was nodding, often nodding, dozing quite unconsciously,
While he sat there by the ingle, smoking, smiling joyously.

The flames were flying upward in a fascinating stream,
There were sparks of fire shooting, like the stars in Heaven's gleam.
The scene at once resplendent lends a joy to me supreme,
As he sits there by the ingle in the glory o' his dream.

Oh that ye could live forever in this pleasant ecstasy,
And your friends be ever wishing, be wishing wistfully,
That in the evening hours of life when Heaven calls its call to thee
Ye'll be found there by the ingle, resting calm and peacefully.

WEELUM

*ingle—hearth, fireplace.
*bonnily—nicely, pretty.

Rationale of Sulfanilamide in Gonococcic Urethritis

One of the authors (Farrell) has treated ten cases of gonorrheal urethritis with sulfanilamide by mouth. Only five of the patients responded to treatment. The other five seemed to derive little benefit from the drug, as evidenced by persistent discharge, so that local treatment was begun. None of the ten patients had any complications such as posterior urethritis, prostatitis or epididymitis. Because of the repeated observations by the various observers that no complications occur, it seemed advisable to James I. Farrell, Evanston, Ill.; Yale Lyman and G. P. Youman, Chicago (*Journal A. M. A.*, April 9, 1938), to determine a rational basis for the use of sulfanilamide in gonorrhea. Large male dogs were used in their experiments. The dogs were given sulfanilamide by mouth for several days, the daily dose being approximately 0.18 Gm. per kilogram. The prostatic fluid of two dogs which had received sulfanilamide intravenously after a sample of normal prostatic fluid had been obtained was tested for germicidal activity. Both samples were tested with Bacillus coli and only one with Staphylococcus aureus. The sulfanilamide is excreted in bactericidal concentrations, in both the urine and the secretion of the posterior urethra, when adequate doses are given. According to the experiments, from 10 to 15 mg. of sulfanilamide seems to be adequate antiseptic concentration. The experiments demonstrate that the bactericidal power of prostatic secretion on colon bacilli and Staphylococcus aureus is marked. In twenty-four hours all the bacteria were reduced in number. In dogs given sulfanilamide in approximately human doses, there were no viable bacteria on the plate at the end of twenty-four hours. The drug appears to act directly on the infecting organisms in the urinary tract.

The 1938 Meeting

OFFICIAL CALL

THE Michigan State Medical Society will convene in Annual Session in Detroit on September 19, 20, 21, 22, 1938. The provisions of the Constitution and By-laws and the Official Program will govern the deliberations.

Henry Cook, M.D.
President
P. R. Urmston, M.D.
Chairman of The Council
Philip A. Riley, M.D.
Speaker

Attest: L. Fernald Foster, M.D., Secretary

* * *

SESSIONS OF THE HOUSE OF DELEGATES

MONDAY, SEPTEMBER 19, 1938

Book-Cadillac Hotel, Detroit

8:00 A.M. Delegates' Breakfast, English Room
9:00 A.M. First Session, Grand Ballroom
3:00 P.M. Second Session, Grand Ballroom
8:00 P.M. Third Session, Grand Ballroom

HOUSE OF DELEGATES, 1938

Book-Cadillac Hotel, Detroit

ORDER OF BUSINESS*

MONDAY, SEPTEMBER 19, 1938

8:00 A.M. sharp—Delegates' Breakfast, English Room.

9:00 A.M. sharp—First Session, Grand Ballroom

1. **Call to Order by the Speaker**
2. **Report of Committee on Credentials**
3. **Roll Call**
4. **Appointment of Reference Committees:**
   - On Officers' Reports
   - On Reports of The Council
   - On Reports of Standing Committees
   - On Reports of Special Committees
   - On Amendments to Constitution and By-Laws
   - On Resolutions
5. **Speaker's Address—Philip A. Riley, M.D., Jackson**
6. **President's Address—Henry Cook, M.D., Flint**
7. **President-elect's Address—Henry A. Luce, M.D., Detroit**
8. **Annual Report of The Council**
9. **Report of Delegates to American Medical Association.**
10. **Reports of Standing Committees:**
    - (a) Legislative Committee
    - (b) Representatives to Joint Committee on Health Education
    - (c) Committee on Distribution of Medical Care
    - (d) Cancer Committee
    - (e) Preventive Medicine Committee (and subcommittees on Degenerative Diseases; Pneumonia; Syphilis; and Tuberculosis)
    - (f) Committee on Postgraduate Medical Education
    - (g) Public Relations Committee
    - (h) Ethics Committee
    - (i) Medico-Legal Committee

Recess

*See the Constitution, Article IV, and the By-laws, Chapter 3, on the "House of Delegates."

MONDAY, SEPTEMBER 19, 1938

3:00 P.M. sharp—Second Session, Grand Ballroom

1. **Supplementary Report of Committee on Credentials**
2. **Roll Call**
3. **Reports of Special Committees:**
   - (a) Maternal Health Committee
   - (b) Contact Committee to Governmental Agencies
   - (c) Mental Hygiene Committee
   - (d) Radio Committee
   - (e) Advisory Committee, Woman's Auxiliary
   - (f) Liaison Committee with Michigan Hospital Association
   - (g) Liaison Committee with State Bar of Michigan
   - (h) Committee on Health League
   - (i) Advisory Committee to Parole Commission
   - (j) Membership Committee
   - (k) Committee on Occupational Disease and Industrial Hygiene.
4. **Unfinished Business:**
   Report on group hospitalization
5. **Resolutions***
6. **New Business***
7. **Reports of Reference Committees:**
   - (a) On Officers' Reports
   - (b) On Reports of The Council
   - (c) On Reports of Standing Committees
   - (d) On Reports of Special Committees
   - (e) On Amendments to Constitution and By-Laws
   - (f) On Resolutions

Recess

MONDAY, SEPTEMBER 19, 1938

8:00 P.M. sharp—Third Session, Grand Ballroom

1. **Supplementary Report of Committee on Credentials**
2. **Roll Call**
3. **Supplementary Report from The Council**
4. **Supplementary Report from Reference Committees**
5. **Elections:**
   - (a) Councilors:
     - Eleventh District to succeed Roy H. Holmes, M.D., Muskegon
     - Twelfth District, to succeed F. C. Bandy, M.D., Sault Ste. Marie
     - Thirteenth District, to succeed B. H. Van Leuven, M.D., Petoskey
     - Seventeenth District, to succeed W. A. Manthei, M.D., Lake Linden
   - (b) Delegates to A.M.A. to succeed:
     - Henry A. Luce, M.D., Detroit
     - Thomas K. Gruber, M.D., Eloise
     - Jacob D. Brook, M.D., Grandville
     - Claude R. Keyport, M.D., Grayling

     Alternates to succeed:
     - T. E. DeGurse, M.D., Marine City
     - C. S. Gorsline, M.D., Battle Creek
     - R. H. Denham, M.D., Grand Rapids
   - (c) Place of Annual Meeting
   - (d) President-elect
   - (e) Speaker of House of Delegates
   - (f) Vice Speaker of the House of Delegates
6. **Adjournment**

*All resolutions, special reports, and new business shall be presented in duplicate.

REFERENCE COMMITTEES

Credentials Committee

A. G. Sheets, *Chairman*
E. O. Foss — John A. Wessinger
P. L. Ledwidge

On Officers' Reports

Founders' Suite
Fifth Floor, Book-Cadillac Hotel

F. J. O'Donnell, *Chairman*
Robt. B. Harkness — A. E. Catherwood
L. W. Day — W. B. Cooksey
C. F. Snapp

On Reports of The Council

Founders' Suite Annex
Fifth Floor, Book-Cadillac Hotel

Donald R. Brasie, *Chairman*
R. L. Wade — H. W. Wiley
A. V. Wenger — O. D. Stryker
R. H. Pino — G. C. Penberthy
W. R. Clinton — A. L. Callery
E. D. Spalding

On Reports of Standing Committees

Parlor H
Fifth Floor, Book-Cadillac Hotel

Stanley W. Insley, *Chairman*
A. T. Hafford — C. F. DeVries
R. E. Spinks — R. C. Jamieson
Otto O. Beck — W. E. Tew
G. H. Southwick — H. W. Plaggemeyer
G. H. Yeo — C. K. Hasley
H. Huntington — L. E. Coffin
L. J. Hirschman — Chas. Ten Houten
W. Joe Smith

On Reports of Special Committees

Parlor I
Fifth Floor, Book-Cadillac Hotel

C. E. Umphrey, *Chairman*
R. L. Finch — R. C. Perkins
J. A. Hookey — W. C. Ellet
A. L. Arnold, Jr. — C. E. Lemen
C. E. Dutchess — E. J. Evans
R. A. Springer — R. J. Hubbell
Palmer E. Sutton

On Amendments to Constitution and By-Laws

Parlor J
Fifth Floor, Book-Cadillac Hotel

Wm. R. Torgerson, *Chairman*
W. D. Barrett — J. M. Robb
J. J. O'Meara — Fred M. Doyle
T. K. Gruber

On Resolutions

Parlor G
Fifth Floor, Book-Cadillac Hotel

F. E. Reeder, *Chairman*
David I. Sugar — R. M. McKean
S. C. Mason — C. R. Keyport
C. E. Toshach

MEMBERS OF THE HOUSE OF DELEGATES, 1938 MICHIGAN STATE MEDICAL SOCIETY

Philip A. Riley, M.D., Jackson, *Speaker*
Martin H. Hoffmann, M.D., Eloise, *Vice Speaker*
L. Fernald Foster, M.D., Bay City, *Secretary*
Names of Alternates appear in italics

1. **Allegan**
   E. T. Brunson, M.D., Ganges
   O. H. Stuch, M.D., Otsego
2. **Alpena-Alcona-Presque Isle**
   F. J. O'Donnell, M.D., Alpena
   A. R. Miller, M.D., Harrisville
3. **Barry**
   Robert B. Harkness, M.D., Hastings
   H. S. Wedel, M.D., Freeport
4. **Bay-Arenac-Iosco-Gladwin**
   R. C. Perkins, M.D., Davidson Bldg., Bay City
   A. D. Allen, M.D., Allen Medical Bldg., Bay City
5. **Berrien**
   Wm. C. Ellet, M.D., Benton Harbor
   Fred Henderson, M.D., Niles
6. **Branch**
   Robert L. Wade, M.D., Coldwater
   Samuel Schultz, M.D., Coldwater
7. **Calhoun**
   Harvey Hansen, M.D., Central Tower, Battle Creek
   A. T. Hafford, M.D., Albion
   Wm. Dugan, M.D., Post Bldg., Battle Creek
   Norman H. Amos, M.D., Central Tower, Battle Creek
8. **Cass**
   S. L. Loupee, M.D., Dowagiac
   C. M. Harmon, M.D., Cassopolis
9. **Chippewa-Mackinac**
   E. S. Rhind, M.D., Rudyard
   J. A. Reese, M.D., DeTour
10. **Clinton**
    A. C. Henthorn, M.D., St. Johns
    D. H. MacPherson, M.D., Fowler
11. **Delta**
    O. S. Hult, M.D., Gladstone
    G. W. Moll, M.D., Escanaba
12. **Dickinson-Iron**
    E. M. Libby, M.D., Iron River
    W. H. Huron, M.D., Iron Mountain
13. **Eaton**
    A. G. Sheets, M.D., Eaton Rapids
    Paul Engle, M.D., Olivet
14. **Genesee**
    Frank E. Reeder, M.D., 808 Genesee Bank Bldg., Flint
    Robert Scott, M.D., 1215 Detroit St., Flint
    Donald R. Brasie, M.D., 907 Citizens Bank Bldg., Flint
    R. S. Halligan, M.D., 405 E. First St., Flint
    D. R. Wright, M.D., 405 W. Court St., Flint
    A. Dale Kirk, M.D., 300 E. First St., Flint
15. **Gogebic**
    W. Ellwood Tew, M.D., Bessemer
    M. J. Lieberthal, M.D., Ironwood
16. **Grand Traverse-Leelanau-Benzie**
    C. E. Lemen, M.D., Traverse City
    None

17. Gratiot-Isabella-Clare
Myron C. Becker, M.D., Edmore
Charles F. DuBois, M.D., Alma

18. Hillsdale
L. W. Day, M.D., Jonesville
O. G. McFarland, M.D., North Adams

19. Houghton-Baraga-Keweenaw
L. E. Coffin, M.D., Painesdale
G. M. Waldie, M.D., Hancock

20. Huron-Sanilac
J. C. Webster, M.D., Marlette
C. W. Oakes, M.D., Harbor Beach

21. Ingham
R. L. Finch, M.D., 124 W. Lenawee, Lansing
C. F. DeVries, M.D., 320 Townsend, Lansing
H. W. Wiley, M.D., 300 W. Ottawa, Lansing
Hewitt H. Smith, M.D., Tussing Bldg., Lansing
O. B. McGillicuddy, M.D., Olds Tower, Lansing
W. Cameron, M.D., American State Savings Bank Bldg., Lansing

22. Ionia-Montcalm
L. E. Kelsey, M.D., Lakeview
C. T. Pankhurst, M.D., Ionia

23. Jackson
Philip A. Riley, M.D., 500 S. Jackson St., Jackson
James J. O'Meara, M.D., 608 Peoples National Bank Bldg., Jackson
H. A. Brown, M.D., 701 Reynolds Bldg., Jackson
C. S. Clarke, M.D., 605 Dwight Bldg., Jackson

24. Kalamazoo-Van Buren
Charles Ten Houten, M.D., Paw Paw
R. J. Hubbell, M.D., 1311 American National Bank Bldg., Kalamazoo
Fred M. Doyle, M.D., 1315 American National Bank Bldg., Kalamazoo
I. W. Brown, M.D., City Health Department, Kalamazoo
Bert Diephus, M.D., South Haven
J. G. Kingma, M.D., Decatur

25. Kent
A. V. Wenger, M.D., Loraine Bldg., Grand Rapids
C. F. Snapp, M.D., Medical Arts Bldg., Grand Rapids
P. W. Kniskern, M.D., Medical Arts Bldg., Grand Rapids
G. H. Southwick, M.D., 55 Sheldon Ave., Grand Rapids
W. R. Torgerson, M.D., Metz Bldg., Grand Rapids
O. H. Gillett, M.D., Metz Bldg., Grand Rapids
John Wenger, M.D., Coopersville
Paul Willits, M.D., Medical Arts Bldg., Grand Rapids
Ward Ferguson, M.D., 6 Park Place, Grand Rapids
J. F. Whinery, M.D., Kendall-Professional Bldg., Grand Rapids

26. Lapeer
Herbert M. Best, M.D., Lapeer
D. J. O'Brien, M.D., Lapeer

27. Lenawee
A. W. Chase, M.D., Adrian
E. T. Morden, M.D., Adrian

28. Livingston
H. Huntington, M.D., Howell
J. J. Hendren, M.D., Fowlerville

29. Luce
R. E. Spinks, M.D., Newberry
E. H. Campbell, M.D., Newberry

30. Macomb
R. F. Salot, M.D., Mt. Clemens
Joseph N. Scher, M.D., Mt. Clemens

31. Manistee
E. A. Oakes, M.D., Manistee
L. W. Switzer, M.D., Manistee

32. Marquette-Alger
Vivian Vandeventer, M.D., Ishpeming
R. A. Burke, M.D., Palmer

33. Mason
L. J. Goulet, M.D., Ludington
C. A. Paukstis, M.D., Ludington

34. Mecosta-Osceola-Lake
G. H. Yeo, M.D., Big Rapids
Glenn Grieve, M.D., Big Rapids

35. Menominee
S. C. Mason, M.D., Menominee
Ed. Sawbridge, M.D., Stephenson

36. Midland
Edwin Place, M.D., Midland
Joseph H. Sherk, M.D., Midland

37. Monroe
D. C. Denman, M.D., Monroe
J. H. McMillin, M.D., Monroe

38. Muskegon
E. O. Foss, M.D., Muskegon Bldg., Muskegon
E. N. D'Alcorn, M.D., Michigan Theatre Bldg., Muskegon
L. E. Holly, M.D., 876 N. Second St., Muskegon
C. J. Durham, M.D., 868 N. Second St., Muskegon

39. Newaygo
O. D. Stryker, M.D., Fremont
W. H. Barnum, M.D., Fremont

40. Northern Michigan
(Antrim, Charlevoix, Emmet and Cheboygan)
F. C. Mayne, M.D., Cheboygan
F. H. Lashmet, M.D., Petoskey

41. Oakland
Otto O. Beck, M.D., 144 W. Maple Ave., Birmingham
Palmer E. Sutton, M.D., Washington Square Bldg., Royal Oak
Zea Aschenbrenner, M.D., Farmington
Ernest Bauer, M.D., 23005 John R. St., Hazel Park
L. A. Farnham, M.D., W. Huron St., Pontiac
A. V. Murtha, M.D., 1105 Peoples State Bank Bldg., Pontiac

42. Oceana
N. W. Heysett, M.D., Hart
Walter Lemke, M.D., Shelby

43. O.M.C.O.R.O. (Otsego-Montmorency-Crawford-Oscoda-Roscommon-Ogemaw)
C. R. Keyport, M.D., Grayling
C. G. Clippert, M.D., Grayling

44. Ontonagon
E. J. Evans, M.D., Ontonagon
C. C. Corkill, M.D., Ontonagon

45. Ottawa
A. E. Stickley, M.D., Coopersville
R. H. Nichols, M.D., Holland

46. **Saginaw**
Clarence E. Toshach, M.D., 333 S. Jefferson Ave., Saginaw
L. C. Harvie, M.D., 405 Wiechmann Bldg., Saginaw
W. K. Anderson, M. D., 316 S. Porter St., Saginaw
S. A. Sheldon, M.D., 515 Building & Loan Bldg., Saginaw

47. **Schoolcraft**
James H. Fyvie, M.D., Manistique
Albert R. Tucker, M.D., Manistique

48. **Shiawassee**
A. L. Arnold, Jr., M.D., Owosso
C. M. Wilcox, M.D., Owosso

49. **St. Clair**
A. L. Callery, M.D., Peoples Bank Bldg., Port Huron
T. E. DeGurse, M.D., Marine City

50. **St. Joseph**
R. A. Springer, M.D., Centreville
None

51. **Tuscola**
T. E. Hoffman, M.D., Vassar
W. P. Petrie, M.D., Caro

52. **Washtenaw**
John A. Wessinger, M.D., 339 E. Washington, Ann Arbor
Dean W. Myers, M.D., St. Joseph Mercy Hospital, Ann Arbor
L. J. Johnson, M.D., 225 E. Liberty, Ann Arbor
F. B. Williamson, M.D., First National Bank Bldg., Ypsilanti
John S. DeTar, M.D., Milan
F. Bruce Fralick, M.D., University Hospital, Ann Arbor

53. **Wayne**
T. K. Gruber, M.D., Eloise Hospital, Eloise
J. M. Robb, M.D., 641 David Whitney Bldg., Detroit
C. E. Umphrey, M.D., 13331 Livernois Ave., Detroit
Ralph H. Pino, M.D., 1001 David Whitney Bldg., Detroit
E. D. Spalding, M.D., 662 Maccabees Bldg., Detroit
R. M. McKean, M.D., 1515 David Whitney Bldg., Detroit
H. W. Plaggemeyer, M.D., 1701 David Whitney Bldg., Detroit
R. C. Andries, M.D., 1737 David Whitney Bldg., Detroit
R. L. Novy, M.D., 662 Maccabees Bldg., Detroit
Wm. R. Clinton, M.D., 113 Martin Place, Detroit
A. F. Catherwood, M.D., 1337 David Whitney Bldg., Detroit
W. D. Barrett, M.D., 311 David Whitney Bldg., Detroit
Douglas Donald, M.D., 938 David Whitney Bldg., Detroit
Grover C. Penberthy, M.D., 1515 David Whitney Bldg., Detroit
Louis J. Hirschman, M.D., 7815 E. Jefferson Ave., Detroit
R. C. Jamieson, M.D., 1551 Woodward Ave., Detroit
Fred H. Cole, M.D., 1757 David Whitney Bldg., Detroit
C. E. Simpson, M.D., 1210 Kales Bldg., Detroit
C. S. Kennedy, M.D., 10 Peterboro St., Detroit
H. F. Dibble, M.D., 1313 David Whitney Bldg., Detroit
Andrew P. Biddle, M.D., 638 David Whitney Bldg., Detroit
C. E. Dutchess, M.D., c/o Parke, Davis & Co., Detroit
Alexander W. Blain, M.D., 2201 E. Jefferson, Detroit
Warren B. Cooksey, M.D., 60 W. Warren St., Detroit
David I. Sugar, M.D., 7310 Grand River, Detroit
Wm. J. Stapleton, Jr., M.D., 641 David Whitney Bldg., Detroit
P. L. Ledwidge, M.D., 1818 David Whitney Bldg., Detroit
C. E. Lemmon, M.D., 1337 David Whitney Bldg., Detroit
J. A. Hookey, M.D., 655 Fisher Bldg., Detroit
C. K. Hasley, M.D., David Whitney Bldg., Detroit
C. F. Brunk, M.D., 7815 E. Jefferson, Detroit
S. W. Insley, M.D., Maccabees Bldg., Detroit
L. J. Bailey, M.D., 510 Professional Bldg., Detroit
R. L. Laird, M.D., 513 David Whitney Bldg., Detroit
Allan McDonald, M.D., 1340 Maccabees Bldg., Detroit
C. F. Vale, M.D., 1306 David Whitney Bldg., Detroit
E. R. Witwer, M.D., Harper Hospital, Detroit
M. H. Hoffmann, M.D., Eloise Hospital, Eloise
H. L. Clark, M.D., 634 Maccabees Bldg., Detroit
F. W. Hartman, M.D., Henry Ford Hospital, Detroit
Wm. S. Reveno, M.D., 951 Fisher Bldg., Detroit
C. D. Benson, M.D., 1515 David Whitney Bldg., Detroit
C. K. Valade, M.D., 1604 Eaton Tower, Detroit
F. A. Weiser, M.D., 1502 David Whitney Bldg., Detroit
J. A. Kasper, M.D., Herman Kiefer Hospital, Detroit
G. L. McClellan, M.D., 1424 Maccabees Bldg., Detroit
F. J. Kilroy, M.D., Receiving Hospital, Detroit
S. E. Gould, M.D., 1432 Longfellow Ave., Detroit
L. J. Gariepy, M.D., 16401 Grand River, Detroit
C. S. Ratigan, M.D., 22340 Michigan St., Dearborn
F. H. Purcell, M.D., 1808 Eaton Tower, Detroit
L. O. Geib, M.D., 3528 Van Dyke, Detroit
L. W. Shaffer, M.D., 1305 David Whitney Bldg., Detroit
Wm. P. Woodworth, M.D., 2994 E. Grand River, Detroit
H. W. Peirce, M.D., 1652 David Whitney Bldg., Detroit
J. W. Hawkins, M.D., 4741 Spokane Ave., Detroit
H. B. Fenech, M.D., 10 Peterboro St., Detroit
H. L. Morris, M.D., 866 Fisher Bldg., Detroit
N. K. H'Amada, M.D., 1018 Maccabees Bldg., Detroit
Geo. Van Rhee, M.D., 10 Peterboro, Detroit
W. B. Harm, M.D., 5884 W. Vernor Highway, Detroit
B. H. Priborsky, M.D., 742 Maccabees Bldg., Detroit
W. N. Braley, M.D., 12897 Woodward, Detroit
Bernhard Friedlaender, M.D., 300 Rowena, Detroit
W. L. Quennell, M.D., Highland Park General Hospital, Highland Park
S. G. Meyers, M.D., 662 Maccabees Bldg., Detroit

54. **Wexford-Kalkaska-Missaukee**
W. Joe Smith, M.D., Cadillac
John Gruber, M.D., Cadillac

SUMMARY OF PROCEEDINGS OF THE HOUSE OF DELEGATES—1937

The Seventy-second Annual Meeting of the House of Delegates of the Michigan State Medical Society was held at Grand Rapids, September 27, 1937.

The House of Delegates:

1. Accepted and adopted with thanks the reports of the Speaker of the House of Delegates (886*), the President (886), the President-elect (886), and the Council (886 and 890-1-2), the Legislative Committee and its subcommittee on Group Hospitalization (887), the Joint Committee on Health Education (887), Medical Economics Committee (887), Cancer Committee (887), Preventive Medicine Committee and its subcommittee on Syphilis Control (887), the Post-Graduate Medical Education Committee (887 and 890), Public Relations Committee (888), Ethics Committee (888), Delegates to the A.M.A. (888), Maternal Health Committee (893), Contact Committee to Governmental Agencies (893), Mental Hygiene Committee (893), Radio Committee (893), Advisory Committee to Woman's Auxiliary (893), Liaison Committee with Hospital Association (893), Liaison Committee with Dentists, Nurses and Pharmacists (893), Joint Report of Committee Studying Schedules A, B, C, D and of the M.S.M.S.-M.H.A.-M.A.R. Committee (893).

2. Adopted an amendment to the Constitution (Art. 5) making the Speaker of the House of Delegates a member of The Council (894).

3. Adopted an amendment to the By-Laws (Chap. 6) substituting the title "Committee on Distribution of Medical Care" for the title "Committee on Medical Economics" (894).

4. Adopted an amendment to the By-Laws (Chap. 4, Sec. 1) relieving the President from the obligation of visiting all the county societies during his tenure of office (894).

5. Adopted an amendment to the By-Laws (Chap. 5, Sec. 2) defining the duties of the Councilor and including therein two visits per annum to each component society in his District (895).

6. Elected the following to Emeritus Membership (895); A. L. Arnold, Sr., Owosso; O. S. Armstrong, Detroit; W. R. Chittick, Detroit; D. W. Fenton, Reading; John Handy, Caro; Levi Harris, Gaylord; A. M. Hume, Owosso (886); J. C. Kugler, Jackson; R. J. Maas, Houghton; A. J. Roberts, Jackson; Edward Sawbridge, Stephenson; Wm. P. Scott, Houghton (895).

Elected to Retired Membership: Edwin J. Witt, Berrien County (895).

7. Ratified action of The Council in transferring Hillsdale from the Third to the Second Councilor District (879-880).

8. Presented scroll to L. G. Christian, M.D., in recognition of his services to Humanity and to Medicine (880-881).

9. Extended an invitation to the A.M.A. to meet in Detroit in 1939, 1940, or 1941 (886).

10. Accepted and adopted a resolution that the Legislative Committee use its influence to make physicians' and nurses' fees, for services rendered in the last illness, first class liens (896).

11. Accepted and adopted a resolution on improvement of morals as part of preventive medicine (896).

12. Accepted and adopted a resolution that the proper committee of the M.S.M.S. confer with all interested groups in order that there may be a proper understanding of the terms "hospital service" and "medical service" in Group Hospitalization plans (896).

13. Accepted and adopted a resolution urging that an inspector be secured for the State Board of Registration in Medicine whose duties shall be to investigate and make charges against violators of the Medical Practice Act (896-7).

14. Accepted and adopted a resolution re fees for medical information in insurance cases, as adopted by the M.S.M.S. in 1939 (897).

15. Accepted and adopted a resolution suggesting that the Michigan State Board of Registration of Nurses study the question of requirements for nurses' training schools and attempt to somewhat modify the present regulations (897-8).

16. Elected:

(a) Henry A. Luce, M. D., Detroit, as president-elect (901)
(b) Philip A. Riley, M.D., Jackson, as Speaker of the House of Delegates (901)
(c) Martin H. Hoffmann, M.D., Eloise, as Vice-speaker of the House of Delegates (902)
(d) T. F. Heavenrich, M.D., Port Huron, re-elected as Councilor of the Seventh District (898)
(e) W. E. Barstow, M.D., St. Louis, re-elected as Councilor of the Eighth District (899)
(f) E. F. Sladek, M.D., Traverse City, elected Councilor of the Ninth District (899)
(g) P. R. Urmston, M.D., Bay City, re-elected Councilor of the Tenth District (899)
(h) G. A. Sherman, M.D., Pontiac, elected Councilor of the Fifteenth District (899)
(i) L. G. Christian, M.D., Lansing, elected Delegate to the A.M.A. (899-900)
(j) G. J. Curry, M.D., Flint, re-elected Alternate Delegate to the A.M.A. (900)
(k) R. H. Pino, M.D., Detroit, re-elected Alternate Delegate to the A.M.A. (900).

17. Referred to The Council the selection of place for the 1938 Annual Meeting (902).

18. Adopted a motion that a medal or charm be purchased for presentation to F. E. Reeder, M.D., Speaker of the House of Delegates for 1936 and 1937, in recognition of long service to the Society (901).

19. Thanked *The Detroit Free Press* for the Medical Supplement (901).

20. Thanked the Grand Rapid hosts and the press for hospitality and publicity (902).

*Numbers refer to pages in the November, 1937, issue of THE JOURNAL of the Michigan State Medical Society.

REPORT OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION, 1938

Because of the necessity of having this report in the hands of our State Secretary on July 1 that it may be included in our Hand Book for the September meeting it will be impossible to give a detailed report of the meeting at this time (June 27). Such a report necessitates a review of the proceedings of the House of Delegates and this will not be completely available until the July 2 edition of *The Journal.*

The eighty-ninth annual session of the American Medical Association was held in San Francisco, California, June 11 to 17, 1938. The attendance up to Friday morning, June 17, totaled 5,970 for the first four days. The Friday registrations will undoubtedly bring the total well over 6,000. Michigan maintained its attitude of loyalty by contributing 98 registrations, which is extremely good considering the time and expense entailed in making the trip.

Michigan again was honored in having two of its delegates appointed to important committee chairmanships. Dr. Henry A. Luce was appointed chairman of the Committee on Amendments to Constitution and By-Laws and Dr. J. D. Brook was appointed chairman of the Committee on Executive Session. While there were 172 delegates registered from forty-eight states, the Sections and various U. S. Possessions, it can be readily seen that two committee chairmanships constituted a lion's share of the available thirteen committees. As usual, and this is perhaps patting ourselves on the back, these two positions were handled by their respective chairmen with dignity, and all material referred was considered and reported with dispatch and directness, while maintaining conservatism and the interests of the doctor back home. Many compliments were received by the two committee chairmen on the character of their reports presented to the House.

Of the material considered by these two committees we submit the following from memory. (Subject to correction from official printed minutes.)

To the Committee on Amendments to Constitution and By-Laws, H. A. Luce, M.D., chairman, was presented the following:

Resolution from Michigan, sponsored by the Council of the State Medical Society and presented by Dr. T. R. K. Gruber, amending the By-laws to create a Public Relations Council of the A.M.A. This resolution and the address of Josephine Roche, read by Dr. W. F. Draper, and referred to the Committee on Executive Session, were the two "wasps' nests" of the meeting.

The last paragraph of the report presented by Dr. Luce expresses, in summary, the thought of the Committee and is presented herewith for your individual interpretation: ". . . to impress upon the Board of Trustees that careful consideration should be given to the operation of our agencies of public information so that on the one hand the necessary 'fortiter in re' may be preserved and on the other that certain deficiencies of 'suaviter in modo' may be corrected."

At the executive session, on Tuesday afternoon, the Committee on Executive Session placed its stamp of approval upon the report of the committee on contraceptive practices as found in the report of the Board of Trustees. It also recommended upon questions presented in a resolution by Dr. Roberts of Georgia concerning the showing of the motion picture film entitled "The Birth of a Baby," that its showing be limited to adults and that whether or not it should be shown to the public was a matter for the various State and County Societies to decide, and recommended that it be so handled.

Upon the address of Miss Roche this same committee cited several inconsistencies in figures and questioned the accuracy of several of her statements and made no recommendations because of a pending joint meeting of organizations represented by Miss Roche, and representatives of the American Medical Association to be held some time during July. (See official proceedings of House of Delegates.)

At this executive session the House resolved itself into the Committee of the Whole for the purpose of considering a resolution sponsored by the New Jersey State Medical Society and introduced by one of its delegates, Dr. Snedecor, severely criticising the activities of Dr. Morris Fishbein for the apparent personal advertising in a "health column" published in about 250 newspapers and for the glamorous newspaper advertising setting forth wonderful information values contained in a book edited by Dr. Fishbein. After presentation of the accusations by Dr. Snedecor, several House members, including the chairman of the Board of Trustees, spoke in defense of Dr. Fishbein. After the latter gave an explanation of the activities in question the resolution was tabled and Dr. Fishbein was given a unanimous vote of confidence.

In regular session, the House of Delegates voted to amend the association's "Ten Commandments" concerning socialized medicine to disapprove the inclusion of special medical services, such as pathological examination, x-ray work and anesthesia, in group hospital contracts and providing for removal of hospitals from association's approval list where either the public or profession is exploited.

The delegates reaffirmed that the House of Delegates is the only body qualified to speak for the American Medical profession and urged members affiliated with other medical societies to work for closer coöperation.

They vigorously opposed a Federal Department of Public Welfare as proposed in the recent reorganization bill and reiterated demands for a cabinet Department of Health with a medical man as secretary.

By action taken at the 1937 meeting, the assembly cities were selected for three years in advance as follows: St. Louis, 1939; New York City, 1940; Cleveland, 1941.

Dr. Rock Sleyster of Wisconsin was elected President, and Dr. H. H. Shoulders of Tennessee was elected Speaker.

For details as to whether this is a country of free speech, particularly as regards newspaper reporters, consult Dr. T. R. K. Gruber.

Subject to the approval of the delegates, additions to this report may be made at the time of the annual State meeting, following a perusal of the official proceedings.

Respectfully submitted,

J. D. Brook, *Chairman.*
H. A. Luce
T. R. K. Gruber
C. R. Keyport
L. G. Christian

ANNUAL REPORT OF LEGISLATIVE COMMITTEE, 1937-38

Your Legislative Committee held four meetings during the past year, on November 10, 1937, February 27, March 30 and May 24, 1938. The first of the above was a joint meeting with the Executive Committee of The Council of the Michigan State Medical Society; the last was a joint meeting with the Policy Committee of the Wayne County Medical Society.

Pursuant to instructions of the House of Delegates, your Legislative Committee studied the possibility of making physicians' fees a first-class lien on estates. An extended survey of the legislation and activities in all the forty-eight states resulted in the conclusion that it would be inadvisable to seek such special privilege from the Legislature, but that the same desirable results could be procured by negotiations with the insurance companies doing business in Michigan. This work is now in process.

Your Legislative Committee respectfully reports that four members of the five-man Basic Science Board were appointed on May 6, 1938. The Attorney General has ruled that the Board as constituted can act legally, pending appointment of the fifth member by the Governor who has been waiting for the nomination of two full-time professors by the Michigan Chiropractic Society, which has not complied with the mandatory requirements of this law.

Your Committee studied the welfare reorganization, to be on the ballot of November 8, and is developing arguments pro and con for dissemination to the members of the Michigan State Medical Society.

Your Committee also studied recommendations re future legal and legislative activities of the State Society; a direct result was action by the State Health Department and the State Board of Registration in Medicine in assigning an inspector to work on violations of the Medical Practice Act. One inspector, however, is not sufficient to take care of the work; there is a need for a generous sum in the budget of the State Board of Registration in Medicine for several inspectors.

The Prenuptial Physical Examination Law was given further study, and various improvements were recommended to the Legislative Committee by the Advisory Committee on Syphilis Control.

The Uniform Narcotic Drug Act was considered, especially Section 3 to which objection was raised on the ground of double taxation on physicians.

The indiscriminate use of the title "Doctor" was surveyed, and the probability of a bill setting forth minimum educational requirements for the title "Dr." was discussed.

Group Hospitalization was studied, and referred to the Liaison Committee with Hospitals; the Medical Practice Act of 1899 was also considered and referred to the State Board of Registration in Medicine for necessary revamping.

The Michigan Health League was organized as a non-profit organization. This League, composed of physicians, dentists, nurses, pharmacists and laymen interested in health can do a great deal of good to protect the health laws of the State, to bring additional health information to the people, and to continue to build up confidence in the medical profession.

Recommendations

1. Your Legislative Committee earnestly recommends that all members of the Michigan State Medical Society take an active interest in the development of the Michigan Health League which is designed to defend the health laws of the State of Michigan, outstanding for their progressiveness.

2. Your Legislative Committee invites attention to the need for a definite sum in the budget of the State Board of Registration in Medicine, for inspectors, and respectfully urges the State Board to seek this necessary appropriation.

3. If the Welfare referendum is defeated, and the 1937 Welfare Laws are declared legal, your Legislative Committee recommends that the State Department of Public Assistance be contacted relative to the early establishment of a medical division, as authorized by Act 257 of the Public Acts of 1937, and that the State Society offer its advice and assistance in outlining the duties of the medical director thereof.

4. Your Legislative Committee repeats its recommendations of 1937 that no aggressive legislative program be planned for the 1939 session of the Legislature, in order that the position we now hold in the eyes of legislators, executive officers of the state, the press, and the general public, shall be maintained and strengthened.

The 1939 Legislative Committee of the Michigan State Medical Society will have to battle harder in order to combat bad legislation—it will have more to *stop*. We shall have to expect much cult legislation in 1939, and bitter attacks against the good health legislation now on the statute books of Michigan.

5. Finally, your Legislative Committee stresses the need for contact, before the 1938 election, with the legislator by his physician-constituents, i.e., his family physician, delegates to the Michigan State Medical Society, keymen in every county of the state, chairmen and members of county medical society policy and legislative committees—with officers of the county medical societies keeping up interest among their membership.

Respectfully submitted,
L. G. Christian, M.D., *Chairman*
Wm. H. Honor, M.D.
H. A. Luce, M.D.
G. L. McClellan, M.D.
A. R. Miller, M.D.
P. R. Urmston, M.D.
O. D. Stryker, M.D.
H. E. Perry, M.D., *Advisor*
J. B. Bradley, M.D., *Advisor*

ANNUAL REPORT OF THE REPRESENTATIVES TO JOINT COMMITTEE ON HEALTH EDUCATION, 1937-38

The Joint Committee on Health Education has had a most productive year, in certain aspects the most productive year in its existence. Since the proceedings of the annual meeting held on June 3 have already been published in The Journal, your attention is directed to this report. At this meeting representatives from the majority of the twenty-seven member organizations were present, and Burton R. Corbus, M.D., of Grand Rapids, was re-elected chairman for the year 1938-39.

We would remind you that one of the most important functions of this committee is to serve as a coördinating unit through which adult and school health educational programs may be conducted. Three committees of the Michigan State Medical Society, during 1937-38, used the facilities of the Joint Committee. The Cancer and Syphilis Committees, each with programs designed to present authentic medical information to the laity, used the machinery of the Joint Committee in giving a total of 110 lectures before adult and professional groups, 72 on "Cancer" and 38 on "Syphilis."

The Radio Committee under the direction of Fred H. Cole, M.D., chairman, conducted a series of twenty-four weekly broadcasts on medical subjects

over eleven radio stations. Dr. Clare Gates, Field Secretary of the Joint Committee, obtained the cooperation of the radio stations, county medical societies and physicians who wrote the manuscripts, and was responsible for sending out the manuscripts weekly.

The Daily Health and Hygiene Column appearing in *The Detroit News* and ten other daily newspapers as well as many weekly newspapers, has been continued. Even though lectures and the radio programs are important channels for the dissemination of authentic medical information which concerns personal and community health, reaching the child through the schools is perhaps more important as a permanent and effective program. The responsibility of adequately instructing the child in matters of personal health and individual responsibility in order to reduce the hazards of preventable diseases, is not incumbent on any one professional or educational group. Desired results unquestionably can be accomplished with greater facility through a community of interest on the part of all interested participants. The Joint Committee can, and does, serve as a medium through which major interest groups may work without losing the identity of the participating unit. To develop a more effective means of instructing the children of Michigan in matters of health, has been a major activity of this past year. Through our sub-committee on School Health Education, instructional aids in the form of bulletins have been printed and distributed to school teachers. An active program to arouse school administrator and teacher interest in health education and to provide more adequate instruction in healthful living for persons who are training to become teachers, has been inaugurated. At the request of the State Department of Public Instruction, the bulletin "Mental, Personal and Social Hygiene," an interpretation of "Sex Education" has been prepared.

The activities of the Joint Committee, therefore, include a continuous program of adult health education and a long range program in school health education which will show less immediate results, but should pave the way for a more sound public conscience on matters of personal and community health.

Respectfully submitted,

BURTON R. CORBUS, M.D., *Chairman*
M. S. CHAMBERS, M.D.
L. FERNALD FOSTER, M.D.
J. B. JACKSON, M.D.
WM. S. REVENO, M.D.

ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE, 1937-38

The Committee on Preventive Medicine held three meetings during the past year: on November 14, 1937, at the Hotel Olds, in Lansing; on January 9, 1938, at the Hotel Durant, in Flint; and on May 22, 1938, at the Statler Hotel, in Detroit. Various activities have been considered, namely:

1. Program on Preventive Medicine

A. *State Medical Meeting.*—The Committee approved the suggestion that it be recommended to the Program Committee of the Michigan State Medical Society that it devote one afternoon of the annual meeting to a symposium on Preventive Medicine, particularly Mental Hygiene, Tuberculosis, Cancer, Industrial Medicine, Syphilis, Maternal Health and Child Care, and Heart Affections. That each sub-committee present to the Program Committee the names of three speakers, one of whom shall represent that committee on the program. Dr. Henry Cook also indicated his willingness to have the President's Night devoted to the subject of Preventive Medicine.

A second Annual Reunion Luncheon will be held at the meeting of the State Medical Society in Detroit, on which occasion, Dr. John Gordon of Boston, will be the speaker. His subject will be "Highlights of Rural Roumanian Medicine."

B. *Regional Conferences.*—The committee recommends that more consideration be given to the subject of Preventive Medicine in the programs at the Regional Conferences. It was agreed that at this time most stress should be on Tuberculosis, and it was suggested that a man be supplied by the Michigan Tuberculosis Association to sit in at the Regional Conferences. Syphilis, Pneumonia, and Cancer were to follow in order as subjects to be taken up at the Conferences.

C. *County Medical Societies* are also urged to devote more meetings annually to the discussion of some of the Preventive Medicine subjects, such as Toxoids, Vaccinations, Tuberculosis, Syphilis, Mental Hygiene, Cancer, Medical Education, Industrial Medicine, School Health, Maternal and Infant Care, and Heart Disease.

2. County Health Units

Again the Preventive Medicine Committee wishes to emphasize the advantages of the formation of County Health Units (not practicing units) in all counties, and that Federal funds are available for such purposes.

3. Medical Director

The Preventive Medicine Committee reiterates its request that funds be sought to employ a full-time medical health director, whose duties shall be to bring the advances in technic of the various tests to the physician in his own office, and with groups of physicians. He should also foster a better relationship between the physicians and the local health departments.

It was the consensus of opinion that the director or directors should work under a grant to the Michigan State Medical Society, but that under present conditions, the Michigan State Medical Society might delegate direction of their activity to the State Health Commissioner.

4. Immunization Schedule

The Preventive Medicine Committee approved the immunization schedule prepared by the Academy of Pediatrics.

5. Appointment of a New Sub-committee on Pneumonia

Approved.

6. Appointment of a New Sub-committee on Degenerative Diseases

Approved.

7. Report of the Sub-committee on Tuberculosis

Submitted by Dr. Bruce H. Douglas, chairman.

8. Report of the Advisory Committee on Syphilis

Submitted by Dr. L. W. Shafer, chairman.

The Committee is indebted to Dr. J. D. Bruce, Vice President, University of Michigan; Dr. M.

R. Kinde, of the Kellogg Foundation; Dr. B. W. Carey, of the Children's Fund of Michigan; Mr. T. Werle, of the Michigan Tuberculosis Association, and Dr. Henry F. Vaughan, Commissioner of Health, City of Detroit, for their attendance at meetings, and for the counsel they have given.

Respectfully submitted,

L. O. Geib, M.D., *Chairman*
G. M. Byington, M.D.
A. L. Callery, M.D.
B. H. Douglas, M.D.
R. B. Harkness, M.D.
Don W. Gudakunst, M.D.
Edgar E. Martmer, M.D.
R. M. McKean, M.D.
J. J. O'Meara, M.D.
H. H. Riecker, M.D.
C. C. Slemons, M.D.
G. C. Stucky, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE ON SYPHILIS CONTROL 1937-38

Sub-committee of the Committee on Preventive Medicine

Meetings of this committee have been held during the last year as follows:

Pantlind Hotel, Grand Rapids, September 30, 1937
Olds Hotel, Lansing, November 14, 1937
Durant Hotel, Flint, January 9, 1938
Statler Hotel, Detroit, May 22, 1938

At the first meeting in Grand Rapids the program for the year was laid out after discussion of the national program and the general principles of the Michigan program as reported in the previous annual report. The type and method of distribution of blanks for certification of applicants for marriage were discussed and approved. Dr. Shaffer was requested to prepare outlines of treatment for the various stages and clinical types of syphilis and present them for approval at the next meeting. The preparation of outlined talks illustrated with lantern slides was placed on the agenda for the next meeting.

At our meeting of November 14, 1937, the outlines of treatment as mentioned above were approved after some changes and recommended for printing in The Journal of the Michigan State Medical Society. The Michigan State Health Department offered to have them printed in pamphlet form and distributed with the free drugs for the treatment of syphilis which they stated would be ready for distribution about January 1, 1938. This offer was unanimously accepted and approved as an effective means of distribution. Drs. Breakey, Pleune, Valade and Shaffer were ordered to prepare an "Outline of Reactions and Complications to Treatment with Technique." This was prepared and turned over to the State Health Department for printing and distribution along with the outlines of treatment. Drs. Bruce and Clare Gates, who were present, offered financial assistance in preparation of lantern slides for the professional and lay educational program. A special committee consisting of Drs. Breakey, Lavan, Valade and Shaffer was requested to prepare these outlines. A special meeting was called in Detroit for this purpose November 21, 1937.

At the meeting of January 9, 1938, the new regulations controlling reporting of venereal diseases were discussed including the new report form. It was admitted that these forms were complicated but contained only necessary information and could be filled out in a minimum amount of time by simply checking the indicated answer. Fees for prenuptial examinations were discussed at length. It was admitted that the medical profession was under pressure from legislators to set a uniform fee for such examinations. If this is not done there is danger that such examinations may be ordered done by physicians on salary to the state. The plea was made by the committee that an endeavor be made to keep such fees on a minimum basis but at the same time they should be commensurate with the services rendered and expenses involved. The importance of holding patients with syphilis, particularly early cases to minimum standards of treatment was discussed. It was recommended that physicians put great emphasis on the initial interview, at which time the medical, social and legal aspects of syphilis be thoroughly and intimately discussed and understood. The problems of venereal disease in indigent patients was discussed and it was recommended that each county medical society contact its board of supervisors relative to payment of a fee to physicians for the care of indigent patients with venereal disease. The outline talks and illustrative slides selected for professional and lay education purposes were approved plus a diversified list of approved speakers. Any physician may be added to this speakers bureau on request when approved by his county medical society.

At our meeting held in Detroit May 22, 1938, the main item for discussion was changes for recommendation to our State Legislature in the present prenuptial physical examination law. It was recommended that where ever the word "venereal" appeared that the terms "syphilis, gonorrhea and chancroid" be substituted. It was likewise recommended that "accepted serologic test for syphilis" be substituted for "Kahn test" where specified in the law. Our most important recommendation was that in such cases where marriage would offer no danger of transmission of syphilis to the marital partner or offspring that a certificate to marry might be granted by the probate judge when approved by a committee appointed by the Commissioner of the Michigan State Health Department consisting of the physician of the person concerned, a medical expert, a representative of the health department and the probate judge. A second problem concerned recommendations on serologic interpretation to be printed on the reverse side of our state serologic report form was discussed at length. No definite action was taken except to recommend that each member of the committee write out his suggestions and send same to the chairman for summary and action at our next meeting. The problem of fees for prenuptial examinations was again discussed. We were unable to reach any definite conclusions except to suggest that all complaints made to the State Health Department be referred to our committee for our information and action.

We feel that many important measures have been instituted towards syphilis control in Michigan during the past year. Our program is however just getting under way and even more important problems still face us. Of these an even more aggressive program for postgraduate instruction must be arranged for the coming year. Approval is desired to refer cases to those physicians who have proven their interest and ability through special training and attendance at courses for postgraduate instruction. The problem of fees still faces us, both for prenuptial physical examinations and for routine treatment of indigent and borderline cases, especially those to be paid for by county or state or both. The question of recommending the total amount of treatment that should be paid for under such a set-up is a difficult one. We have still to formulate

our recommendations on serologic interpretation. These are only a few of the many problems facing us in the future.

Respectfully submitted,
LOREN W. SHAFFER, M.D., *Chairman*
ROBERT S. BREAKEY, M.D.
R. S. DIXON, M.D.
GEORGE HAYS, M.D.
ROY H. HOLMES, M.D.
WM. A. HYLAND, M.D.
JOHN LAVAN, M.D.
HAROLD R. ROEHM, M.D.
C. K. VALADE, M.D.
UDO J. WILE, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE ON TUBERCULOSIS CONTROL, 1937-38

Sub-comittee of the Committee on Preventive Medicine

This Committee was organized for active work November 14, 1937, at which time Dr. Henry Cook, president of the State Medical Society, laid before the Committee some of the problems which he wished to see solved in connection with bringing together the practicing physicians of the state and the various voluntary and public health agencies interested in a tuberculosis control program. The coördination of the efforts of the various agencies, including the medical profession, in providing better facilities for case finding in tuberculosis was therefore accepted as the principal objective for the committee's work.

Several meetings have been held during the year with representatives of the State Health Department, Michigan Tuberculosis Association, and Michigan Association of Roentgenologists. Out of these conferences has come a much better understanding of the aims and objectives of the various groups and a splendid spirit of coöperation for the better handling of tuberculosis case finding.

The following definite projects have been undertaken:

1. Postgraduate instruction for physicians in the field of tuberculosis case finding has been arranged for the regional postgraduate conferences to be held at various centers this fall.
2. The Michigan Association of Roentgenologists has considered the matter of special attention to the problem of making x-ray services easily available in those communities where there are specialists in this field and have indicated that they are willing to make this service available for persons who can pay at very reasonable fees and for those who cannot, the work will be done for a much reduced fee when paid by a public health agency or some other interested organization.

The roentgenologists have definitely recognized the important place that the x-ray examination of the chest plays in any effort to find and diagnose tuberculosis.

The following recommendations have been made by the Committee and accepted by the Preventive Medicine Committee and The Council of the State Medical Society:

1. That tuberculosis case finding by tuberculin testing and the x-ray examination of positive reactors is recommended as a valuable procedure.
2. Examination of immediate family contacts to all known cases of tuberculosis as well as of those whose symptoms might suggest tuberculosis should be undertaken more extensively by all physicians.
3. That the reimbursement of the physician and the roentgenologist on a nominal fee basis when the patient cannot pay for the service is deemed essential.
4. That at the proper time funds be sought through the State Health Department for this purpose.
5. Pending the time when funds may be available to stimulate work on a state wide basis that attention be given to a few counties where the tuberculosis mortality and morbidity is high in the hope that provision for increased effort in case finding may be made in these areas.
6. And finally that local coöperation be sought throughout the whole state so that there will not be a duplication of effort by county sanatoria, county health units, tuberculosis societies, county medical societies and other agencies particularly interested in the fight against tuberculosis.

The work of this committee is just getting well under way and it is hoped that a committee of this sort may be continued for another year.

Respectfully submitted,
BRUCE H. DOUGLAS, M.D., *Chairman*
R. B. HARKNESS, M.D.
GEORGE C. STUCKY, M.D.
B. A. SHEPARD, M.D.
E. R. WITWER, M.D.
GEORGE SHERMAN, M.D.
A. W. NEWITT, M.D.

ANNUAL REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY OF THE STATE SOCIETY, 1937-38

The advisory committee of the Woman's Auxiliary to the Michigan State Medical Society has had two meetings this year, and the chairman has met with the Executive Committee of The Council and with Mrs. Hicks, president of the State Auxiliary, upon several occasions. A large amount of committee work has been conducted by correspondence.

At the beginning of the year the committee recommended the following activities:

1. Organization of a woman's auxiliary to each county medical society.
2. That each auxiliary member become civic minded; be a good club woman; and be a member of as many community groups as possible.
3. That she inform herself on state medicine in order to give the medical point of view.
4. That she become a member of the Michigan Health League.
5. That the woman's auxiliary assist the state medical society in its program on public health education; promote radio health programs sponsored by the medical society; and stimulate public interest in social hygiene, cancer education, tuberculosis, syphilis and maternal health.

The committee is pleased to report that the component units of the state auxiliary have as far as possible carried out these recommendations. Three new county auxiliaries have been organized—Newaygo, Lapeer and Washtenaw. Lay women's organizations throughout the state have shown a friendly attitude to the auxiliary which is an indication that members have become civic minded and are interested in community problems. There is no way to determine how much good has come from discussions on state medicine but it is believed that auxiliary members have informed themselves on this most vital question.

The auxiliary has assisted the state society in its program on public health education which is resulting in an increasing demand for medical speakers at lay meetings.

The Executive Committee of The Council directed the advisory committee to make a survey of the needs for a state benevolent fund. Questionnaires

were sent to every county society. Tabulation of the replies is as follows:

1. County societies in Michigan.....54
2. Number of replies.....43
3. Percentage of replies.....79%
4. Counties stating need for benevolent fund among physicians 9
5. Counties stating need for benevolent fund in woman's auxiliaries 3
6. Counties opposed to fund on basis it is not needed 27

The results of this survey indicate that there is no need for a benevolent fund in Michigan. Most of the questionnaires made emphatic comments opposed to it. Two or three counties have a local benevolent fund which is administered in conjunction with the county medical society. It is difficult to understand that the need is so demanding as to warrant the maintaining of funds that might be used more advantageously for educational purposes in health programs.

At the last meeting of the committee the question of complete revision of the constitution and by-laws of the state auxiliary was discussed. It is recommended that an analysis be made and changes be considered as a major project during the coming year. It would seem that the constitution and by-laws of the state woman's auxiliary might be patterned after that of the state medical society. One of the suggested changes is for a smaller board of directors of seven members: president, president-elect, three past presidents, secretary and treasurer. A large board like the one at present consisting of the officers and chairmen of all committees is too unwieldy to function well.

The committee realizes the importance of a woman's auxiliary to the state medical society. The constantly changing social, economic and professional structure of our national government has created many controversial medical questions that must be intelligently explained to the laity. Women's organizations have always been valuable adjuncts to those of man. Today, more than ever before, man realizes the need of women's help in his government, his business and his profession.

The advisory committee wishes to pay a tribute to the woman's auxiliary for its unselfish interest and splendid coöperation in the mutual problems that have arisen during the year. The committee makes a personal appeal to the members of the Michigan State Medical Society that they become interested in the work of the auxiliary; that they attend the meetings to which they are invited; and that they cease to consider the woman's auxiliary as merely a social adjunct to their society.

Respectfully submitted,
HARRISON S. COLLISI, M.D., *Chairman*
FLORENCE AMES, M.D.
CLAIRE W. STRAITH, M.D.
HAROLD W. WILEY, M.D.
GORDON H. YEO, M.D.

ANNUAL REPORT OF THE RADIO COMMITTEE, 1937-38

The second series of weekly broadcasts on medical subjects was conducted over eleven radio stations in the state. Starting in November and ending in April, twenty-four weekly programs were given through the coöperation of eleven county medical societies. It will be recalled that last year the Radio Committee called upon the several committees of the State Society to assume responsibility for the preparation of a designated number of radio scripts on subjects appropriate for the particular committee. This year, it was decided to ask some qualified physician to prepare each script. The subject titles and the persons responsible for preparing the manuscripts are as follows:

Ideals in Medicine.....W. J. Stapleton, Jr., M.D.
First Aid to the Injured.....R. M. Bartlett, M.D.
Colds and Their Complications.....W. H. Marshall, M.D.
Means of Self-protection Against Cancer.....
Henry J. Vanden Berg, M.D.
*Is It True in Dentistry?.....C. Wilford Wilson, D.D.S.
Hearing .....Emil Amberg, M.D.
Appendicitis.....C. D. Brooks, M.D.
Discipline of the Child in the Light of Intra-family Relationships.....Louis A. Schwartz, M.D.
Tuberculosis in the Child.....Bruce Douglas, M.D.
*Two Aids for Good Teeth.....K. R. Gibson, D.D.S.
Pneumonias .....Hugo A. Freund, M.D.
Surgery .....Charles G. Johnston, M.D.
The Next Great Plague to Go.....Loren W. Shaffer, M.D.
Heart Disease, Real and Imaginary..Frank N. Wilson, M.D.
*Pyorrhea.....Clayton H. Gracey, D.D.S.
Common Eye Troubles.....Ralph H. Pino, M.D.
Maternal Health.....A. M. Campbell, M.D.
Gonorrhea.....Robert S. Breakey, M.D.
Anesthetics.....Henry K. Ransom, M.D.
*X-Ray's Place in Dentistry.....Ronald B. Fox, D.D.S.
Asthma and Some Other Forms of Allergy.....
Stanley W. Insley, M.D.
Modern Weapons in the Fight Against Tuberculosis...
A.M.A. Script
Safety Through Vaccine and Serums.....
Edgar E. Martmer, M.D.
Importance of Diagnosis.....A.M.A. Script

The Joint Committee on Health Education, through its field secretary, Clare Gates, assumed the responsibility of obtaining the coöperation of the country medical society, the radio stations and physicians who prepared the manuscripts. The participating medical societies and coöperating radio stations are listed below.

County Medical Society	City	Station	Time
Bay	Bay City	WBCM	12:30 P.M.
Calhoun	Battle Creek	WELL	6:30 P.M.
Genesee	Flint	WFDF	1:15 P.M.
**Houghton-Baraga-Keweenaw	Calumet	WHDF	6:45 P.M.
**Ingham	Lansing	WJIM	11:00 A.M.
Jackson	Jackson	WIBM	9:00 A.M.
Kalamazoo	Kalamazoo	WKZO	1:45 P.M.
Kent	Grand Rapids	WOOD	1:00 P.M.
Marquette-Alger	Marquette	WBEO	5:30 P.M.
Muskegon	Muskegon	WKBZ	11:00 A.M.
Wayne	Detroit	CKLW	7:45 P.M.

Time and facilities donated by radio stations approximate $5,000, based on regular commercial rates. We call your special attention to the time of day that was allotted by the radio stations. No greater compliment could be given to an unsponsored (donated time) program by radio stations than that extended to us in giving voluntary time on the air during such favorable hours of the day.

The Committee feels deeply grateful for the unstinted coöperation of all those who have contributed their time and services toward making this program a success.

Respectfully submitted,
FRED H. COLE, M.D., *Chairman*
ROBERT S. BREAKEY, M.D.
F. M. DOYLE, M.D.
C. D. HART, M.D.
C. F. SNAPP, M.D.

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*The State Dental Society accepted the invitation to cooperate and contributed four talks. Local dentists read these talks on each occasion.

**Coöperated this year but not last year.

ANNUAL REPORT OF COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION, 1937-38

The registration in the courses in postgraduate medicine from July 1, 1937, to June 30, 1938, is as follows:

Extramural Courses		
Battle Creek-Kalamazoo		183
Bay City		154
Flint		132
Grand Rapids		173
Lansing-Jackson		170
Traverse City-Cadillac-Manistee-Petoskey		96
Marquette		39
Sault Ste. Marie-Ironwood, Marquette-Houghton-Escanaba		103
Grayling-Alpena-Petoskey-Traverse City		274
		1324
Intramural Courses		
Ann Arbor		
Electrocardiographic Diagnosis	33	
Ophthalmology & Otolaryngology	65	
Diseases of Metabolism	35	
Diseases of Blood	29	
Personal Courses	226	
Detroit		
General Medicine	28	
Pediatrics	29	
Proctology	18	
Urology	4	
Obstetrics & Gynecology	16	483
	Total	1807

In the extramural course, 353 physicians attended from 50 to 100 per cent of the eight presentations.

The attendance from outside the State increased about 15 per cent over the preceding year.

A full report of the Committee's activities for the first half of the year was presented at the annual meeting of the Council in January, 1938, and reported in the March issue of THE JOURNAL, Michigan State Medical Society.

A meeting of the Postgraduate Committee was held at the Wayne County Medical Building, Detroit, at 2:15 P.M., April 20, 1938.

Present: Dr. R. B. Allen, Dr. H. H. Cummings, Dr. C. T. Ekelund, Dr. D. W. Gudakunst, Dr. G. C. Penberthy, Dr. F. E. Reeder, Dr. D. I. Sugar, Dr. Henry Cook, Dr. H. A. Luce, Dr. J. H. Dempster, Dr. P. R. Urmston, Dr. L. F. Foster, Secretary; Mr. Wm. J. Burns, Executive Secretary; Dr. James D. Bruce, Chairman.

Absent: Dr. A. P. Biddle, Dr. B. R. Corbus, Dr. W. B. Fillinger, Dr. G. A. Kamperman, Dr. R. R. Smith, Dr. C. C. Slemons.

The first item was the selection of subject matter for the extramural course for the coming year. Twenty-two subjects were considered and the following selected:

1. Fever of unknown origin.
2. The cardiac arrhythmias.
3. Diagnosis and treatment of the more persistent skin lesions.
4. The State's interest and responsibility in the problems of mental disease. The possibilities of coöperative action in the care of the mentally diseased.
5. Mental hygiene of the adult.
6. The doctor and the child.
7. Geriatrics. The care of the aged.
8. The indications for the use of certain drugs.
9. Peripheral vascular disease, including the care of varicosities and ulcers.
10. Intracranial and intraspinal injuries.
11. The Michigan Tuberculosis Association—a cooperative agency.
12. The physician and the tuberculosis problem.
13. The indications for surgery in tuberculous and non-tuberculous lesions.
14. The care of the infant at birth.
15. Preventive measures in infancy and childhood.
16. Pelvic inflammatory disease.
17. Management of hemorrhage in pregnancy.
18. Nephritis.

On account of numerous interruptions which have prevented a maximum of attendance during September and again in November, the Committee decided to divide the program between the spring and the autumn, selecting the months of October and April as probably of greater convenience to the profession. The subject matter for October, 1938, will be as follows:

1. Symposium on tuberculosis, its economic, social and clinical aspects.
2. Symposium on mental hygiene.
3. (a) Intracranial and intraspinal injuries.
   (b) Vascular disease of the extremities.
4. (a) Dermatology. Treatment of the more persistent skin lesions.
   (b) Management of diseases of old age.

Numerous communications have come to the Committee from time to time from physicians in the 14th district, who felt that the establishment of a more convenient center would stimlulate attendance in that area. This was decided upon and on account of hospital accommodations and teaching facilities the University Hospital at Ann Arbor was selected for the coming year.

From time to time the profession of Saginaw has wished to share the extramural course with Bay City. The chairman of The Council visited the Saginaw profession, and a formal request was made that the 1938-39 program be given in Saginaw. As this seems satisfactory to both communities, the Advisory Committee has accepted the suggestion and the autumn course will be given in Saginaw.

From a number of communities has come the suggestion that a change of hours for the conferences would add to the convenience of the doctors, making possible a larger attendance. Accordingly, each community is being given the privilege of selecting the hours most acceptable to it. These changes of both location and hours will appear in THE JOURNAL as well as in the announcements.

It was brought out in the discussion that occasionally it has been difficult to provide a different teacher for each center and oftentimes on account of his special interests or fitness it has seemed desirable to employ one man for several or all centers. The Committee agreed that the number of speakers utilized should be governed by their fitness and availability.

Notwithstanding the many methods of notification which have been used by the Committee to inform the profession of the time and place of meetings, many doctors explain their failure to attend to lack of notice. The methods employed have been two or three preliminary notices of the general progam in THE JOURNAL of the American Medical Association, and beginning early in the year and continuing throughout the period of the courses prominent notices have been given in THE JOURNAL of the Michigan State Medical Society. In addition to these, notices are sent to all members of the Society in advance of the first courses of the year, which usually begin in February, and another notice is sent in advance of the autumn courses. Press releases also are sent to all the larger newspapers of the State.

So that there be no possibility of inadequate notification, it was decided that the Executive Secretary send an additional notice to all members of the Society a few days in advance of the beginning of the autumn courses.

The question of the possibility of securing a con-

tinuation study center in Detroit under the University of Michigan, Wayne University, or both, through securing financial aid from Federal funds has been under discussion for some months. This possibility had been raised by Mr. Burns when he learned of the Minneapolis continuation center built by Federal funds, now operated by the University of Minnesota, and which contains living quarters for some seventy-five people as well as class rooms for the use of the various professional groups. Dean Allen of Wayne University Medical School expressed himself favorable to the idea but saw many difficulties in the assumption of responsibility by Wayne University or by a combination of Wayne and Michigan, and Dr. Bruce felt that the difficulties outlined by Dean Allen applied with equal force to the participation of the University of Michigan. However, acquiring a center of this character by either University, or through a combination of interests seems so desirable that it was felt the subject should continue to be explored by Executive Secretary Burns, Dean Allen and Dr. Bruce.

It will be recalled that in response to a request of several state societies, transmitted by the Massachusetts State Medical Society, for representation at a meeting called for the Atlantic City session of the American Medical Association in June, 1937, The Council requested the chairman of the Advisory Committee on Postgraduate Education to represent the Michigan State Medical Society. At this meeting, an accounting of which has already been given, the Associated Postgraduate Committee was organized and the chairman of the Michigan Advisory Committee on Postgraduate Education elected chairman. The chairman being unable to attend the San Francisco meeting on account of Commencement exercises at the University of Michigan, it was suggested that Dr. H. A. Luce or Dr. P. R. Urmston, who would be in attendance, present the address of the chairman. In communication with the other officers of the Associated Postgraduate Committee, it was felt that a regional chairman of the Committee would more appropriately preside and present the address of the chairman. Accordingly, Dr. Thomas P. Farmer of Syracuse, New York, represented Dr. Bruce.

It will be recalled that your chairman presented a supplemental report on postgraduate certification at the last annual meeting of the Society, and a form presented at this time was accepted tentatively. All records of attendance have been carefully reviewed and the registrants have been given opportunity to correct any possible errors. The list of those entitled to certification has been forwarded to the Executive Secretary and the certificates will be prepared and ready for distribution at the annual meeting of the Society, in accordance with the action of the House of Delegates.

It was felt by the Committee that postgraduate attendance should have two formal recognitions. First, an "Associate Fellowship in Postgraduate Education," designated by a certificate with the seal of the Society in silver, to be awarded on fulfillment of the first four-year attendance, or its equivalent; the second, a "Fellowship in Postgraduate Education," designated by a certificate with the seal of the Society in gold, to be awarded after a second period. It further provided that the subject matter of the four-year work may be concentrated in a period of one year for Associate Fellowship and over a two-year period for Fellowship.

A matter causing much concern to state examining boards, educators and the profession is that of the quite general inadequacy of the teaching of interns throughout the entire country. More and more the value of the present hospital provision for the intern is being questioned, and it would seem if the additional year required of the medical graduate is justified that a more definite supervision should be contemplated and provided. In addition to the discussion at the last committee meeting, your chairman has discussed this matter with the National Committee on Graduate Education and with prominent physicians in different parts of the country. All are agreed that our obligation to the intern is not being fulfilled, and that the usual association with hospital staff members, no matter how friendly and interesting, is not a substitute for the more formal educational opportunities which this fifth year contemplated. As a first step in meeting this situation, it is suggested that a few hours once a month, preferably the latter part of the afternoon, be given over to a formal professional program, to be participated in by the interns and senior members of the profession. This has been discussed with the deans of both our medical schools, as well as a number of members of both faculties, and all are favorable to assuming this obligation. It is suggested that if undertaken the program be confined to a three-hour period, alternating once a month between Ann Arbor and Detroit for the first year, with a view of extending the periods and also later rotating the program in the various larger hospitals of the State.

There are a number of Committees of this Society that are definitely educational in character, and as such should bear a certain amount of responsibility in the formulation of postgraduate policies. While there has not been opportunity to discuss this matter with the Postgraduate Committee, your chairman at this time makes the suggestion that the chairmen of the following committees be included as members, or at least ex-officio members, of the Committee on Postgraduate Education: Cancer Committee, Preventive Medicine Committee, Maternal Health Committee, and Mental Hygiene Committee. The inclusion of the chairmen of these committees would, it is believed, materially strengthen the Committee on Postgraduate Education.

Respectfully submitted,

JAMES D. BRUCE, M.D., *Chairman*
R. B. ALLEN, M.D.
A. P. BIDDLE, M.D.
B. R. CORBUS, M.D.
H. H. CUMMINGS, M.D.
C. T. EKELUND, M.D.
W. B. FILLINGER, M.D.
D. W. GUDAKUNST, M.D.
G. A. KAMPERMAN, M.D.
G. C. PENBERTHY, M.D.
F. E. REEDER, M.D.
C. C. SLEMONS, M.D.
R. R. SMITH, M.D.
D. I. SUGAR, M.D.
T. G. YOEMANS, M.D.

ANNUAL REPORT OF THE COMMITTEE ON MATERNAL HEALTH, 1937-38

1. The Committee has been mostly concerned with completing the report of the Michigan Obstetric Study in the hope of having it in printed form for presentation at an early date. Because of other pressing duties devolving upon Dr. Carroll E. Palmer of the United States Public Health Service, the completion of the data has been delayed much beyond the expectation of the Committee. It is hoped, however, that a full report can be presented in pamphlet form at the annual meeting in Detroit.
2. The Committee has been interested in the release of the sound movie film, entitled, "The Birth of a Baby" and members of our Committee, after attending prevues of this film, were

unanimously in favor of its being released for public presentation. The Committee has heartily indorsed this film.

3. The Committee is happy to report that a Committee on Maternal Health is now appointed in every County Medical Society in the State, and that some of these Committees are extremely active in problems pertaining to Maternal Health in their communities. The State Committee has made certain recommendations to the Executive Committee of the Council with the purpose of activating these various Committees and acquainting them with their duties and opportunities in the field of Maternal Health.
4. The Committee indorsed a proposal made by Dr. J. D. Bruce and Dr. D. W. Gudakunst that a competent Obstetrician be appointed for approximately two months in the Upper Peninsula, to hold meetings and Clinics with Physicians, and be available for consultation. The Committee's approval of this proposal however, depends upon whether or not the majority of the physicians in the Northern Peninsula are in favor of this plan.
5. The Committee has gone on record in a former report concerning the scarcity of Obstetrical Clinical material at the University Hospital, and on June 7, of this year, it gave its unanimous approval of a plan suggested by Dr. Gudakunst, Health Commissioner of Michigan. This plan provides for a special appropriation of $30,000, annually, to be used to help defray the expenses for additional clinical cases in the Obstetrical department in Ann Arbor.
6. The Committee has been interested in the type of Obstetrical Service furnished in the proprietary hospitals in the State which are licensed by the State Welfare Department, and one of the members of the Committee is making an investigation of this subject.

The Committee desires to acknowledge the excellent coöperation it has had from the United States Public Health Service and from the Executive Committee and from other officers of the Michigan State Medical Society during the year.

Respectfully submitted,

ALEXANDER M. CAMPBELL, M.D., *Chairman*
HAROLD A. FURLONG, M.D.
A. DALE KIRK, M.D.
NORMAN F. MILLER, M.D.
WARD F. SEELEY, M.D.
HAROLD W. WILEY, M.D.

ANNUAL REPORT OF CONTACT COMMITTEE TO GOVERNMENTAL AGENCIES, 1937-38

During the past year, your Committee held eight meetings, seven being in Lansing. In addition, the members made individual contacts with various governmental officials, agencies, and allied groups.

The principal matter referred to your Committee for study was amendments to the schedules under the Afflicted-Crippled Children Laws. Two meetings with the Michigan Crippled Children Commission, on February 15, and on March 2, were held. In addition, your Chairman was delegated to discuss necessary revisions in the schedules with the Auditor General of Michigan and with a representative of the Michigan Crippled Children Commission in Lansing on June 1. The result of this meeting was the final recognition of our radiologists and anesthetists as independent practitioners of medicine, with their fees inserted in Schedules A and C—an important principle for which these doctors of medicine and the Michigan State Medical Society had been fighting for five years.

Another important subject referred to the Contact Committee was liaison work with the Governor's Medical Survey Committee. Three meetings were held with the Governor's Committee on March 2, May 4 and May 21.

Another problem referred to the Contact Committee was the investigation of medical care being accorded to employees of state institutions in lieu of salary, the service being given by physicians employed by the state to serve the inmates. A meeting on April 14 with Mr. Wm. Brownrigg, Personnel Director of the Civil Service Commission, was followed by meetings on June 22 with Doctor Joseph Barrett, Director, State Hospital Commission, and with Mr. Hilmer Gellein, Director of the Department of Corrections. A satisfactory understanding of the problem resulted from these contacts and discussions.

During the past year, your Committee met with a representative of the Michigan Department of Public Instruction to discuss school problems of the exceptional child. Technical advice was gladly given, and additional conferences on this matter are indicated.

Work of this committee is of extreme importance to the medical profession of the state. The Chairman has frequently, this year, been required to appear before various groups and address them, as well as to preside at sections, thereby showing that the medical profession of the state is interested in the problems of various other groups. Through these contacts much good will is built up for the profession. It also gives the medical profession a viewpoint just a little different from our own and keeps us abreast of the work and effort being put forward by various other agencies interested in health and allied activities. The Committee urges, therefore, that this work shall be carried on, ever exerting the influence of the profession where needed as well as developing an appreciation of the medical profession and of the fact that physicians really are interested in public problems.

HENRY COOK, M.D., *Chairman*
HENRY A. LUCE, M.D.
P. R. URMSTON, M.D.
WM. J. BURNS

ANNUAL REPORT OF THE MENTAL HYGIENE COMMITTEE, 1937-38

The Committee on Mental Hygiene, recognizing the dangers in an unscientific approach to the subject of mental health and being thoroughly of the opinion that mental hygiene is a problem of health, has tried to lay the foundation of the committee's work on a real medical scientific basis.

With this end in view, early in the year the Committee decided that all material sponsored by the committee should be subjected to review by a selected number of the committee.

Your Committee would recommend to the Society that all publications on this or allied subjects in THE JOURNAL not sponsored by this committee be carefully reviewed by a competent board. It is becoming increasingly important that articles published in official journals of medical societies be carefully reviewed, because articles thus published have the appearance at least of being approved by the organization and thus accrue unwarranted standing.

Several articles in THE JOURNAL have been sponsored by the Committee and the Committee feels a pardonable pride in having arranged the details for an address by Dr. Winfred Overholser to the Public School Principals of Detroit and Public Health

Workers on April 27, 1938, at the auditorium of Wayne College of Medicine.

Your Committee again wishes to call to the attention of the membership the need for a continuing increase in postgraduate training as well as undergraduate teaching. Mental health has assumed such importance that your Committee feels that it would be derelict in its duty should it fail to attempt to arouse the profession to its responsibility for a thorough scientific understanding of the components of mental health.

Respectfully submitted,

H. A. LUCE, M.D., *Chairman*
E. H. CAMPBELL, M.D.
R. L. DIXON, M.D.
M. H. HOFFMANN, M.D.
R. C. MOEHLIG, M.D.
R. A. MORTER, M.D.
THEOPHILE RAPHAEL, M.D.
R. L. SCHAEFER, M.D.
R. W. WAGGONER, M.D.
O. R. YODER, M.D.

ANNUAL REPORT OF THE ETHICS COMMITTEE, 1937-38

The Ethics Committee of the Michigan State Medical Society wishes to offer its annual report to the House of Delegates.

The major complaint which this committee was called upon to study involved a general misunderstanding between two groups of doctors in central Michigan. The Ethics Committee ordered a hearing on the matter for all those concerned on Sunday, March 20, 1938 and we believe that the matter was adjusted with complete satisfaction to everybody. The defendant admitted that he had made a rather grave mistake and apologized for it in the presence of his accusers and the three members of the committee who were at the hearing. All of the records including the stenographic notes of both sides are now on file in the central office at Lansing.

There were a number of minor matters that were apparently adjusted by correspondence. We believe that the men are sticking closer together and hewing closer to the line of ethics than ever before—a very good sign in these days when the magazines are taking a full swing at the medical profession in general. We choose to submit our annual report without the mention of any specific names.

Respectfully submitted,

HORACE WRAY PORTER, M.D., *Chairman,*
L. C. HARVIE, M.D.
EARL G. KRIEG, M.D.
R. C. PERKINS, M.D.
LEMOYNE SNYDER, M.D.

REPORT OF MEDICO-LEGAL COMMITTEE, 1938

As requested by the Executive Committee of the Council we have prepared for the "Handbook of the Delegates" this partial report of the work of the Medico-Legal Committee. The regular report is made annually at the January meeting of The Council. This report is from January 1, 1938 to June 1, 1938. So much of the work is of such a confidential nature that it is thought unwise to publish the names in full. So far this year the following list gives briefly the new cases that have had papers served upon them. We have omitted names and addresses but outlined the reason very briefly. You realize that there are always cases awaiting trial. Sometimes several years elapse before the cases actually get into court.

Dr. A.—Broken needle following injection of vaccine.
Dr. B.—Alleged malpractice in two operations.
Dr. C.—Suit because of alleged slandering.
Dr. D.—Suit just coming to trial after 1½ years. (fracture).
Dr. G.—Alleged poor results in gunshot wound.
Dr. G.—Alleged poor results following use of dinitrophenol.
Dr. H.—Burn resulting from use of cautery.
Dr. I.—Alleged malpractice following treatment of fracture.
Dr. J.—Alleged malpractice following treatment of fracture.
Dr. K.—Alleged malpractice following operation (repair).
Dr. K.—Alleged malpractice following hemorrhoids.
Dr. M.—Alleged malpractice following ulcers of leg.
Dr. M.—Alleged malpractice following confinement.
Dr. O.—Not a member. Alleged malpractice following removal of tonsils.
Dr. P.—Record not in yet. Suit.
Dr. R.—Alleged malpractice following circumcision.
Dr. T.—Alleged malpractice following burns.
Dr. T.—Alleged malpractice following fracture.
Dr. S.—Threat re burn following deep therapy.
Dr. W.—Suit re bad results following treatment of leg wound. Dues not paid.
Dr. Z.—Suit re bad results following treatment of fracture.

Right here we suggest that particular attention be paid to any case taken care of for the various welfare organizations, either city, county, state or national. Be sure your records are complete.

You will note the variety of reasons for the alleged malpractice. Five of the cases are fractures—here we stress again the use of x-ray before and after reduction and before discharge. Courts now hold that the exercise of ordinary skill and care requires the use of x-ray in diagnosis and treatment.

We would also call attention to the use of the various electrical and diathermy machines, hand lamps, et cetera. Burns resulting from the above are frequent causes for suits. We should bear in mind that the acts of the assistant or nurse using these under the doctor's direction makes the physician liable. We would also urge caution in the use of some of the newer and unaccepted drugs on the market. There are numerous cases in the courts regarding the use of dinitrophenol.

The matter of wrong diagnosis is another cause. It is well to have competent consultation in all doubtful cases.

We could go on and enumerate many other matters of interest to the doctor. In the past years our reports have pointed out various things to be avoided.

Malpractice is always with us. Many cases are just plain blackmail with no justification whatever. We feel that every doctor should be on his guard constantly so as to avoid any reason, real or alleged, for a malpractice suit. It behooves every one of us, general practitioner or specialist, to be very careful how we act toward people who come to us for treatment. Especially is this true when the patient complains about treatment received from another doctor. An unwise statement, the shrug of a shoulder or a skeptical tone may be the basis for a malpractice suit.

Again we suggest that doctors acquaint themselves with their rights and liabilities under the law. Remember, "Ignorance of the Law is no excuse." We suggest also that physicians read over the Harrison Narcotic Act. Be sure and register as required by law on the right date. The Commission is getting tired of doctors forgetting this important matter and there will be less leniency in the future. Don't forget also your registration under the new Michigan Narcotic Act.

The law, like medicine, never stands still. New laws are enacted constantly; new decisions are rendered daily in our Supreme Courts. So we of the medical profession should seek to keep abreast of the changes relating to medicine so that we may know the danger and thus keep from assuming unnecessary obligation. This Committee is your source of any legal information you may need.

Along the lines of preparedness we suggest the reading of the following books:

Medical Relations under Workmen's Compensation. American Medical Association, Price 65c postpaid. Such subjects as choice of physician, character of service rendered under various conditions, amount and forms of payment, and different methods of organizing the medical service were exhaustively considered and are covered in the report. The book is of vital interest to all physicians and surgeons having industrial connections. It is also a work that touches on problems of interest to all members of the medical profession.

Medicolegal Cases. Abstracts of Court Decisions. This volume will not make a physician his own lawyer, but will help avoid legal difficulties. Published by A.M.A., $5.50.

Courts and Doctors. Stryker, The MacMillan Co., New York, $2. An excellent little volume.

The Doctor in Court. Edward H. Williams, M.D. Williams & Wilkins Co., Baltimore, $2.50. Fine for expert testimony.

Perceval's Medical Ethics. Lake. Williams & Wilkins Co., Baltimore, $3. Every doctor should read this classic.

Medical Jurisprudence. Scheffel. Balkeston & Co. A good small volume for reference.

Medical Ethics. A rereading of the little red book published by the A.M.A. is worth while.

The Committee works as a sort of clearing house for all sorts of questions and is always ready to help in any way.

We respectfully submit this report for the consideration of the Delegates to the Annual Meeting. It is suggested that each Delegate make himself a committee of one to help stamp out the modern racket, "Malpractice."

ANGUS MCLEAN, M.D., *Chairman,*
WM. J. STAPLETON, JR., M.D.,
Secretary.
S. W. DONALDSON, M.D.
I. W. GREENE, M.D.
WM. R. TORGERSON, M.D.

ANNUAL REPORT OF IODIZED SALT COMMITTEE, 1937-38

A sub-committee meeting of the Iodized Salt Committee was held February 23, 1938, at 12:30 noon at the Detroit Club, together with the committee from the Salt Manufacturers' Association represented by Mr. Morse, Secretary, and Mr. Ostrom, Advertising Manager of the Morton Salt Company, who came from Chicago on purpose for this meeting. Our sub-committee, listed to you before, was F. B. Miner, M.D., T. J. Cooley, M.D., David J. Levy, M.D., and Edgar Martmer, M.D.

A general program for educational purposes was discussed and many suggestions were made. It was decided that Mr. Ostrom would draw up a tentative program to be submitted to Dr. D. W. Gudakunst, State Health Commissioner, and Dr. Martmer for their approval, the final program to be submitted both to the Michigan Department of Health and the Iodized Salt Committee of the Michigan State Medical Society for their approval.

It was suggested that a member of the State Board of Education be invited to meet with Dr. Gudakunst, Mr. Ostrom and Dr. Martmer in preparing the program.

On May 7 the sub-committee reported, making recommendations for advertising propaganda. This has been considered by all the members of the Committee and is now in process of revision. In other words, we are not ready to give our approval to any educational propaganda that has been proposed up to the present time.

Respectfully submitted,
D. MURRAY COWIE, M.D.,
Chairman,
THOMAS J. COOLEY, M.D.
DAVID J. LEVY, M.D.
EDGAR E. MARTMER, M.D.
ROY D. MCCLURE, M.D.
FRED B. MINER, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH HOSPITAL ASSOCIATION, 1937-38

Your committee held three meetings during the past year, one on March 16, 1938 at the Wayne County Medical Society Building with representatives of the laity interested in the subject of group hospitalization, such as representatives of the Detroit Health Council, the Detroit Education Association, the Detroit Board of Commerce and the Detroit Council of Social Agencies; another at the Wayne County Medical Society on April 13, with representatives of the Michigan Hospital Association interested in the same subject; and the last on May 18, with the Executive Committee of The Council and officers of the Michigan State Medical Society, together with the Trustees of the Michigan Hospital Association.

In order to fulfill the instructions of the House of Delegates, which adopted a Resolution on this subject last year, your committee limited its formal work during the past twelve months to the study of group hospitalization. At its first meeting, it discussed two fundamental questions: (a) Should the medical profession be against any hospital service corporation in Michigan? and (b) if not, should any enabling act be general in scope, or contain details covering plans for group hospitalization?

Your committee felt that the medical profession ought to offer its advice in such an important matter as group hospitalization, in order that — — — should an enabling act be passed by the Legislature, it will have the ideas of the medical profession incorporated therein. (It will have the advantage of the medical profession's assistance in technical matters.) In answer to the second question, the Committee seemed to favor detailed statements in any law, and to that end developed preliminary recommendations for consideration by the medical society and the hospital association.

At the second meeting of your committee, these recommendations were discussed "as a plan for operation which may later form the basis of an agreement for enabling acts." The recommendations re group hospitalization as agreed upon *in part* by your Liaison Committee and a similar committee of the Michigan Hospital Association on April 13, 1938, follows:

"That hospital service or group hospital insurance, by whatever name called, shall include or exclude as hereinafter provided, the following:

"1. Hospital care if needed, up to a minimum of 21 days within each contract year, may be given on one or more ad-

missions; and shall include such other benefits as to number of days' care as may be found actuarily sound.

"2. The members shall be entitled to the following services in a participating hospital when such services are requested by his or her physician for in-patient care only, such per diem allowance and such bed accommodations as may be actuarily sound. The services included for the per diem allowance shall be (a) bed and board, (b) dietetic service, (c) operating room if actuarily possible, (d) surgical dressings and ordinary medications. (e) general nursing service, (f) interne and resident service where available, provided that resident service shall not be substituted for the services of a private physician, (g) emergency hospital care in any hospital anywhere up to a determined amount, (h) ambulance service in metropolitan areas as may be determined and upon the doctor's recommendation, (i) maternity cases including use of delivery room and nursing service not to be acceptable until after an agreed waiting period.

"3. Hospital care shall be construed to mean those services set forth in the paragraphs above and shall be given to members in accordance with the By-Laws of group hospital service or group hospital insurance as it may be incorporated, which are made a part of this contract; (a) the benefits offered by an agreement not to include the services of member's attending physician or surgeon, radiologist, **pathologist,* anesthetist,*** special nurses or their board; (b) hospital care for pulmonary tuberculosis (after diagnosis as such), venereal diseases, quarantinable diseases, alcoholic or drug addicts, mental disorders, or hospital care which is provided without cost to the members under the laws enacted by the legislature of any state, or the Congress of the United States (as for example, Workmen's Compensation Laws) are not included in the benefits offered by this agreement.

"4. Services under this agreement shall be rendered only upon the authorization and request of the member's physician, who must be acceptable to the selected hospital and be licensed to practice medicine in Michigan, or in the state where the emergency service is rendered. No right is conferred upon any hospital to select a physician or surgeon for the member.

"4A. Hospital care shall continue only during the time that the member is under the treatment and care of his or her physician in accordance with his staff privileges at such hospital, and will end at the time that the member is discharged as a hospital patient by his or her physician. The member will be responsible to the hospital for payment for services rendered in such hospital and which are not included in this agreement.

5.* **Any local or state-wide group hospital insurance under this plan that is organized in this state shall include on the Board of Directors an equal medical representation, this medical representation to be appointed by the local County Society or the State Medical Society.**

"6. The rates, charges, and premiums to be charged the public for the hospital service and for the certificate therefor, and the certificates and benefits thereunder, herein provided for shall at all times be subject to the approval of the Superintendent of Insurance, and shall be adequate to meet the liability assumed under such contracts and all expenses incurred in connection therewith. †**The Trustees of the Michigan Hospital Association in conjunction with the Executive Committee of The Council of the Michigan State Medical Society shall have the right, subject to the approval of the Superintendent of Insurance, to prescribe reasonable rules and regulations under and by which all certificate holders can procure the services herein provided for.**"

The above recommendations were discussed at length at the meeting of May 18, held in Eloise Hospital, with officials of both the medical society and the hospital association. No final determination was made regarding the items at issue in Sections Three and Five and Six.

The matter at the present time is on the table for further discussion at a future conference, by mutual agreement of those present at the meeting of May 18.

The House of Delegates of the American Medical Association has recommended that medical services be excluded from group hospitalization contracts. The medical profession is convinced that the inclusion of medical services "in kind" in group hospitalization contracts will have an undesirable effect on the practice of medical specialties in hospitals, and therefore on the quality of the services rendered. Two proposals have been suggested as a solution to the problem of medical services in group hospitalization contracts: (1) restrict the benefits of the contract exclusively to the use of hospital facilities such as bed and board, operating room, medicines, surgical dressings and general nursing care; and (2) pay cash benefits directly to the insured for all medical services.

Your Committee has been attempting to follow the A.M.A. policy. It respectfully requests the House of Delegates of the Michigan State Medical Society to instruct it as to whether it shall continue on this course, or whether any changes or modifications are indicated at this time.

Respectfully submitted,

T. K. GRUBER, M.D., *Chairman*
G. J. CURRY, M.D.
I. W. GREENE, M.D.
REUBEN MAURITS, M.D.
PLINN MORSE, M.D.
E. R. WITWER, M. D.

*No determination made at meeting of April 13, 1938.
†The final sentence of Section 6 is to be re-drafted.

EXHIBITORS AT 1938 MICHIGAN STATE MEDICAL SOCIETY CONVENTION

Book-Cadillac Hotel, Detroit, September 20, 21, 22, 1938

Name of Company	City	Booth No.
Akron Truss Company	Detroit, Mich.	75
A. S. Aloe Company	St. Louis, Mo.	4
Arlington Chemical Company	Yonker, N. Y.	15
Bard-Parker Company, Inc.	Danbury, Conn.	7
Bilhuber-Knoll Corporation	Jersey City, N. J.	38
Burroughs Wellcome & Co. Inc.	New York, N. Y.	12
S. H. Camp Company	Jackson, Mich.	22
Coca-Cola Company	Atlanta, Ga.	70
Cottrell-Clarke, Inc.	Detroit, Mich.	64
R. B. Davis Sales Corp.	Hoboken, N. J.	66
Detroit X-ray Sales Corp.	Detroit, Mich.	59
Dictaphone Sales Corp.	Detroit, Mich.	71
Duke Laboratories, Inc.	Long Island City, N. Y.	52
Electray Equipment Company	Detroit, Mich.	33
General Electric X-ray Corp.	Chicago, Ill.	53
Gerber Products Company	Fremont, Mich.	45
Gordon Shoe Co.	Detroit, Mich.	72
Hack Shoe Company	Detroit, Mich.	3
Hanovia Chemical & Mfg. Co.	Newark, N. J.	5, 6
J. F. Hartz Company	Detroit, Mich.	54
H. J. Heinz Company	Pittsburgh, Pa.	43
Holland-Rantos, Inc.	New York, N. Y.	36
Horlick's Malted Milk Corp.	Racine, Wis.	28
G. A. Ingram & Company	Detroit, Mich.	62, 63
Jones Metabolism Equipment Co.	Chicago, Ill.	8
The Jones Surgical Supply Co.	Cleveland, Ohio	56
A. Kuhlman & Company	Detroit, Mich.	69
Lea & Febiger Company	Philadelphia, Pa.	55
Lederle Laboratories	New York, N. Y.	25
Libby, McNeill & Libby	Chicago, Ill.	68
Liebel-Flarsheim Company	Cincinnati, Ohio	50
J. B. Lippincott Company	Philadelphia, Pa.	9
M. & R. Dietetic Labs.	Columbus, Ohio	47
Mead Johnson & Company	Evansville, Ind.	29, 30
Medical Arts Pharmacy	Grand Rapids, Mich.	26, 27
Medical Case History Bureau	New York, N. Y.	40
Medical Protective Company	Wheaton, Ill.	39
The Mennen Company	Newark, N. J.	48
Merck & Company	Rahway, N. J.	10, 11
The Wm. S. Merrell Company	Cincinnati, Ohio	46
C. V. Mosby Company	St. Louis, Mo.	2
Nestle's Milk Products Co.	New York, N. Y.	16
Parke, Davis & Company	Detroit, Mich.	17, 18, 19, 20
Pelton & Crane Company	Detroit, Mich.	57, 58
Pet Milk Sales Corp.	St. Louis, Mo.	41, 42
Petrolagar Laboratories, Inc.	Chicago, Ill.	67
Philip Morris Company, Ltd.	New York, N. Y.	21
Physicians Equip. Exchange	Detroit, Mich.	73
Picker X-ray Corporation	Chicago, Ill.	23
Pocahontas Fuel Company	Detroit, Mich.	74
Professional Management	Battle Creek, Mich.	65
Randolph Surgical Supply Co.	Detroit, Mich.	13, 14
Sandoz Chemical Works, Inc.	New York, N. Y.	24
W. B. Saunders Company	Philadelphia, Pa.	49
Smith, Kline & French Labs.	Philadelphia, Pa.	34, 35
E. R. Squibb & Sons	New York. N. Y.	44
Frederick Stearns & Co.	Detroit, Mich.	60, 61
Van Hoosen Farm	Rochester, Mich.	37
Vernor's Gingerale	Detroit, Mich.	1
Wall Chemicals Company	Detroit, Mich.	31
John Wyeth & Brother, Inc.	Philadelphia, Pa.	32
The Zemmer Company	Pittsburgh, Pa.	51
Zimmer Manufacturing Co.	Warsaw, Ind.	76

Your patronage of these friends who are supporting the Michigan State Medical Society is earnestly recommended.

President's Page

HEALTH PROGRAMS REQUIRE JOINT EFFORT

AT THE recent meeting of the Michigan School Health Education Institute in Ann Arbor, I offered the following thoughts:

All people want health. But many do not know how to obtain it, and a good percentage who may know are not willing to make the effort to obtain it.

Never before has there been so great a general interest in the health of our people as now. Outside of the medical profession, voluntary health agencies, foundations and philanthropists, as well as writers and others are busily propagandizing Health. Some few are not willing to approach the problem fairly and honestly, do not recognize all sides of the question, or approach it with preconceived ideas. Fortunately, however, most realize the truth and are working from facts. Good results are being obtained, especially in the increase of public interest in the subject of health.

Coöperation with the medical profession in all these efforts always brings more beneficial results. Any health program requires confidence and joint effort between all parties concerned. There must be a thorough knowledge by persons or groups interested in a health program as to what are the aims and purposes of the project. Every fair effort must be put forward to place the program foremost in the objective; the whole plan must be executed on a strictly ethical basis.

The medical profession has always been willing to give its aid and advice in medical problems which have to do with health whenever they have been honestly sought. Those organizations successfully dealing with health today recognize this ethical need and are strictly adhering to it.

In a word, no health program is eminently successful when the medical viewpoint is ignored. On the other hand, more favorable returns are achieved when the technical advice and active assistance of the profession are sought and obtained.

Members of the Michigan State Medical Society: In line with these statements, I know you stand ready to render whole-hearted coöperation to any who are sincere in their efforts to make Michigan the most healthy commonwealth in the nation.

Henry Cook

President, Michigan State Medical Society.

DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

EXECUTIVE COMMITTEE OF THE COUNCIL

May 18, 1938

HIGHLIGHTS:

1. **Group Hospitalization discussed with trustees of the Michigan Hospital Association.**
2. **Matters for presentation to the A.M.A. House of Delegates in San Francisco discussed with Michigan's Delegates to the A.M.A.**
3. **Letter to M.S.M.S. membership re: Supreme Court Amendment, sponsored by the State Bar of Michigan, given approval.**
4. **Proposed new building for the Army Medical Library and Museum in Washington, D. C., approved.**
5. **Personnel of the Basic Science Board, as appointed by the Governor, announced.**
6. **Woman's Auxiliary Annual Meeting Program, to be held in Detroit, September 20, 21, 22, approved.**
7. **Consolidation of Delta and Schoolcraft County Medical Societies recommended to M.S.M.S. House of Delegates.**
   Elimination of one Councilor District (the present 13th District) recommended to the Council for presentation to the M.S.M.S. House of Delegates.
8. **Revision of brochure "Who Wants Socialized or State Medicine!" given approval.**
9. **The August Meeting of the entire Council arranged.**

1. *Roll Call.*—The meeting was called to order at 2:15 p. m. by Dr. P. R. Urmston, chairman, at Eloise Hospital, Eloise, Michigan.

2. *Minutes.*—The minutes of the meeting of April 14 were read and approved.

3. *Financial Report.*—The monthly financial report was presented. Dr. Moore suggested that future monthly reports show the relation of expenditures to the budget, and also a present worth statement of the bonds. Motion of Drs. Moore-Carstens that prior to the monthly meeting of the Executive Committee, the Committee on Bonds (Drs. Carstens, Hyland and Moore) be furnished a list of the bonds, to make a financial report on the condition of the assets at the meetings of the Executive Committee. Carried unanimously.

Motion of Drs. Carstens-Brunk that the bills, as presented, be paid. Carried unanimously.

4. *Committee Reports.*—(a) Medico-Legal Committee: The monthly report, presented in a letter from Dr. Stapleton, was read, accepted and ordered placed on file.

(b) Advisory Committee to Woman's Auxiliary report was presented in a letter from Dr. Collisi: no need for a Benevolent Fund at this time was indicated. Motion of Drs. Carstens-Moore that this portion of the report be accepted and placed on file. Carried unanimously. The budget of the Woman's Auxiliary for its convention in Detroit, September, 1938, was presented. Motion of Drs. Moore-Carstens that the sum of $150 be allowed for this purpose. Carried unanimously. Program of the Woman's Auxiliary Convention in Detroit, September, 1938, was approved on motion of Drs. Carstens-Brunk and carried unanimously.

(c) Report of the meeting with Mr. Brownrigg of the Civil Service Dept. was given by Secretary Foster. Dr. Gruber stated that Eloise's employees do not receive medical care, in lieu of salaries. Motion of Drs. Carstens-Brunk that this be referred to the Contact Committee with Governmental Agencies. Carried unanimously.

(d) Postgraduate Medical Education Committee report was given by Dr. Cook. Accepted and placed on file.

(e) Contact Committee with Governmental Agencies report was given by Dr. Cook. He outlined the activities of the Governor's Medical Survey Committee with meetings on May 4 and May 21.

The matter of news releases re the A.M.A. Survey was presented and discussed. Motion of Drs. Carstens-Moore that the Contact Committee to Governmental Agencies prepare appropriate releases, with the Executive Secretary. Carried unanimously. The report of the committee was accepted and placed on file.

(f) Committee of Radiologists on Attorney General's opinion: Dr. Moore presented this report, which was accepted and placed on file.

(g) Liaison Committee with Hospital's report was given by Dr. Gruber. A discussion ensued on group hospitalization.

Wayne S. Ramsey, M.D., Executive Secretary of the Crippled Children Commission, was introduced to the members of the Executive Committee, who welcomed him to Michigan.

5. *Annual Meeting.*—Dr. Foster gave a progress report on the annual meeting in Detroit next September. He recommended an Internes' Conference for Monday, September 19, which was approved.

6. *Upper Peninsula Secretaries' Conference.*—Dr. Foster reported on this Conference held in Marquette, May 15, and attended by Councilors Bandy and Manthei, Secretary Foster and Executive Secretary Burns, at which the A.M.A. Survey and other activities and problems were presented.

An invitation to send representatives to the June Conference of Health Officers at Mackinac was read. Motion of Drs. Riley-Moore that the Secretary and the Executive Secretary be authorized to attend this conference, as representatives of the M.S.M.S. Carried unanimously.

7. *Schoolcraft-Delta County Medical Societies Merger; also Elimination of the Councilor District.*—Secretary Foster presented the request of the two county medical societies for a merger. Motion of

Drs. Brunk-Moore that the Executive Committee of The Council recommend to the House of Delegates this consolidation, in accordance with the desires of the two county medical societies. Carried unanimously.

The Secretary also presented the request of the Alpena-Alcona-Presque Isle County Medical Society to be joined with the Tenth Councilor District (it is now in the 13th Councilor District); and also the request of the Northern Michigan County Medical Society (Antrim, Charlevoix, Cheboygan, Emmet counties) to be joined with the 9th Councilor District (it is now in the 13th Councilor District). This would eliminate the 13th Councilor District. The Secretary suggested that if the 13th Councilor District were abandoned, that the present 17th Councilor District (comprising the counties of Menominee, Dickinson, Iron, Gogebic, Ontonagon, Houghton-Keweenaw-Baraga) be re-numbered to District No. 13—permitting the Upper Peninsula to have Districts Nos. 12 and 13—and eliminating 17 as the number of a Councilor District. The state would then be divided into sixteen Councilor Districts. Motion of Drs. Carstens-Riley that the Executive Committee recommend to the Council, at its August meeting, that this matter be referred, as recommended, to the House of Delegates. Carried unanimously.

8. *August Meeting of The Council.*—Drs. Urmston and Foster invited the Councilors and the Officers to hold their August meeting at Point Lookout, north of Bay City. This could be arranged on a Sunday.

9. *Membership for Army, Navy, and U. S. Public Health Service Physicians.*—A letter from the Wayne County Medical Society relative to membership in the M.S.M.S. for these physicians was presented and discussed. The matter will be held until the next meeting of the Executive Committee.

10. *Brochure on "Who Wants Socialized or State Medicine!"*—The possible revision and dissemination of a revised brochure on this subject was presented by Secretary Foster and generally discussed. Motion of Drs. Carstens-Riley that the Public Relations Committee be authorized to prepare a revised brochure and present it and the cost for same at a future meeting of the Executive Committee. Carried unanimously.

11. *Spot Speakers Service.*—This suggestion was presented by Secretary Foster, as an end result of the A.M.A. Survey. The secretary was instructed to contact the Chairman of the Joint Committee and report at the next meeting of the Executive Committee.

12. *Instructions to A.M.A. Delegates.*—Matters for presentation at the San Francisco meeting of the A.M.A. were discussed by the Delegates and the Executive Committee of The Council.

13. *Request of State Bar of Michigan.*—The request of the State Bar for approval of a letter to be sent to all members of the M.S.M.S. re the Supreme Court Amendment was presented and thoroughly discussed. Motion of Drs. Moore-Brunk that the letter as corrected be sent out to the M.S.M.S. members on the Supreme Court Amendment Committee's stationery, and signed by Dr. Luce as a member of that committee. Carried unanimously.

14. *Army Medical Library and Museum, Washington, D.C.*—A letter from the A.M.A. relative to this proposed building was read. Motion of Drs. Carstens-Riley that the Secretary be directed to send letters to Michigan's senators and representatives to the U. S. Congress, recommending that adequate housing of the medical library be given consideration; and further, that all the county medical societies in Michigan be urged to take similar action. Motion carried.

15. *Basic Science Board.*—The Executive Secretary announced the appointment by the Governor of four of the five members of the Basic Science Board, as follows: W. O. Nelson, Wayne University, Detroit, pathology and anatomy; Fr. George Shiple, University of Detroit, chemistry; Ralph C. Huston, Michigan State College, physiology; J. P. Van Haitams, Calvin College, Grand Rapids.

16. *Birth Certificates.*—The matter of a few individual physicians failing to file birth certificates was presented and referred to the State Board of Registration in Medicine.

Recess: The meeting was recessed at 6:00 p. m. for dinner.

Joint Meeting of Executive Committee of The Council and of the Liaison Committee with Hospitals, M.S.M.S, together with trustees of the Michigan Hospital Association

17. The meeting was called to order by Dr. Urmston, at 8:00 p. m. Present, in addition to those indicated above, were: Drs. J. Stewart Hamilton, E. R. Witwer, W. L. Babcock, W. G. Gamble, F. W. Hartman, Messrs. R. G. Greve, Ralph Huston, Wm. J. Griffith, Mr. Corneil, Miss J. Jackson, Mrs. George Wadley.

18. *Group Hospitalization.*—The Chair called upon Dr. Gruber to explain the activities of the Liaison Committee, and to present the recommendations of April 13. These were discussed, item by item. In Section 3, long discussion on the inclusion or exclusion of pathologists and anesthetists resulted in a motion by Dr. Gruber and Mr. Griffith that the matter be laid on the table for further discussion at a future conference. Motion carried 11 to 3.

19. *Thanks.*—A vote of thanks was placed on the minutes of the Executive Committee of The Council to Dr. Gruber for his hospitality in having this meeting at Eloise Hospital.

20. *Adjournment.*—The meeting was adjourned at 11:12 p. m.

COUNCIL AND COMMITTEE MEETINGS

1. Wednesday, June 22, 1938—Representatives to Michigan Health League—Hotel Olds, Lansing—12:00 noon.
2. Wednesday, June 22, 1938—Contact Committee to Governmental Agencies—Lansing, 3:00 p. m.
3. Thursday, June 30, 1938—Executive Committee of The Council—Ann Arbor—6:00 p. m.

STATE SOCIETY MEETINGS

"State Society Meetings" will be held in all of the County Medical Societies of the Upper Peninsula during August. Officers and Councilors of the State Society are making their annual tour. The tentative itinerary is as follows:

August 8—Menominee
August 9—Escanaba
August 10—Iron Mountain
August 11—Ironwood
August 12—Ontonagon (noon)
August 12—Houghton (night)
August 16—Marquette
August 17—Newberry
August 18-19—Sault Ste. Marie (Annual Meeting of Upper Peninsula Medical Society)

SUPPLEMENTARY ROSTER

The following physicians, whose names did not appear in The Directory Number of THE JOURNAL, are members of the Michigan State Medical Society:

Allegan County

Dolce, James A.....Allegan
Horner, B. F.....Otsego

Bay-Arenac-Iosco-Gladwin Counties

Burton, Horace French....East Tawas

Branch County

Chipman, E. M.....Quincy

Calhoun County

Hansen, Harvey C.....Battle Creek
Zinn, Karl.....Battle Creek

Genesee County

Leach, J. L.....Flint
Martin, Donald W.....Flint
Rosenblum, H. G.....Flint
Schiff, B. A.....Flint
Winchester, W. H.....Flint

Grand Traverse-Leelanau-Benzie Counties

Swanton, L. .....Traverse City

Ionia-Montcalm Counties

Crunican, A. J.....Hubbardston
Breece, Raymond .....Grand Rapids
MacKenzie, Earl.....Detroit

Kent County

Allen, R. V.....Grand Rapids
Bell, Charles M.....Grand Rapids
Bishop, T. P.....Grand Rapids
Bolender, J. E.....Grand Rapids
Breece, Raymond .....Grand Rapids
DeYoung, T. .....Sparta
Doran, Frank .....Grand Rapids
Farber, Charles E.....Grand Rapids
Faust, L. W.....Grand Rapids
Fellows, K. E.....Grand Rapids
Gibbs, F. F.....Grand Rapids
Grant, Lucile R.....Grand Rapids
Hilt, Lawrence .....Grand Rapids
Hollander, Stephen.....Grand Rapids
Hoogerhyde, Jack.....Grand Rapids
Houghton, G. D.....Caledonia
McBride, George L.....Grand Rapids
Pott, A. L.....Grand Rapids
Reus, Wm. F.....Jamestown
Rodgers, Williams ....Grand Rapids
Sculley, Ray E.....Grand Rapids
Stover, Virgil E.....Grand Rapids
Thompson, Archibald B., Grand Rapids
Thompson, Athol B...Grand Rapids
Thompson, P. L.....Grand Rapids
Tiffany, Joseph C.....Grand Rapids
Winter, G. E.....Grand Rapids

Midland County

Rice, Robert E.....Midland

Ottawa County

Coburn, Milan.....Coopersville

Saginaw County

Alger, G. L.....Saginaw

Wayne County

Altshuler, Ira M.....Detroit
Atchinson, Russell M.....Northville
Atler, Lawrence R.....Detroit
Bachman, Morris E.....Detroit
Bergo, Howard L.....Detroit
Besancon, John H.....Detroit
Bevington, H. G.....Detroit
Bower, Franklin T.....Detroit
Braitman, Louis .....Detroit
Bringard, Elmer .....Detroit
Brown, A. O.....Detroit
Burnstein, I. Marvin.....Detroit
Bush, L. M.....Detroit
Carey, Cornelius .....Detroit
Carter, L. F. .....Detroit
Clausen, Claire H.....Detroit
*Coolidge, Maria Belle.....Detroit
Coseglia, Robert P.....Detroit
Dixon, Fred W.....Detroit
Donald, Douglas .....Detroit
Durocher, E. J.....Ecorse
Eades, Charles C.....Detroit
Epstein, S. G. .....Detroit
Erman, Joseph M.....Detroit
Fellman, Abraham R.....Detroit
Fenech, Harold B.....Detroit
Freeman, Benjamin F.....Detroit
Gage, David P.....Detroit
Goldstone, R. R.....Detroit
Gottschalk, F. W.....Detroit
Grant, Lee F.....Detroit
Greenberg, Morris Z.....Detroit
Greenidge, Robert.....Detroit
Grekin, Joseph .....Detroit
Hall, James A. J.....Detroit
Havers, Howard .....Detroit
Henderson, L. T.....Detroit
Hodges, Roy W.....Detroit
Howard, Austin Z.....Detroit
Howell, Bert F.....Detroit
Howlett, Howard T.....Detroit
Hubbard, Leighton R.....Detroit
Jackson, Fred D.....Detroit
Kennary, James M.....Detroit
Kennedy, William Y.....Detroit
Kowalski, Valentine L.....Detroit
Lawrence, Wm. C.....Detroit
Leaver, L. Ross .....Detroit
Lee, H. E.....Detroit
Levitt, Edward J.....Detroit
Lynn, David H.....Detroit
MacKenzie, Earl .....Detroit
MacKenzie, R. D.....Detroit
Markoe, R. C. L.....Detroit
Martin, R. M.....Detroit
Mateer, John G.....Detroit
McClellan, R. J.....Detroit
McClendon, James J.....Detroit
McLaughlin, Nelson.....Detroit
McLean, Harold G.....Detroit
McQuiggan, Paul.....Detroit
Moloney, J. Clark.....Detroit
Morand, L. J.....Detroit
Moriarty, George .....Detroit
Novy, R. L.....Detroit
Plaggemeyer, H. W.....Detroit
Rexford, Walton K.....Detroit
Robertson, S. B.....Detroit
Robertson, T. H.....Detroit
Sandler, Nathaniel.....Eloise
Schillinger, H. K.....Detroit
Scott, Robert J.....Detroit
Shawan, H. K.....Detroit
Skully, E. J.....Detroit
Smith, James A.....Detroit
Spero, Gerald D.....Detroit
Steiner, Max .....Detroit
Stern, E. A. .....Detroit
Sullivan, H. A.....Detroit
Tassie, Ralph N.....Detroit
Tenaglia, Thomas A.....Ecorse
Thomas, J. T., Jr.....Detroit
Tryon, Mary .....Detroit
Turbett, S. O.....Detroit
Valade, C. K.....Detroit
Walker, J. Paul.....Detroit
Watson, Robert W.....Highland Park
Wellard, Henry O.....Detroit
Wilson, F. S.....Detroit
Young, James P.....Detroit

*Dr. Coolidge was erroneously listed in the M.S.M.S. Roster in the Directory Number under Grosse Pointe. Her name should have been listed with the physicians in Detroit.

COUNTY SOCIETIES

ALLEGAN COUNTY

W. M. German, M.D., Grand Rapids, addressed the members and their ladies and the local dentists and their ladies on June 7 at Allegan. Doctor German gave a very entertaining and instructive travelogue through Mexico. The guests were entertained during dinner by fine orchestra music. All members were present except two; the total attendance was sixty-two. Two new members were accepted, James A. Dolce, M.D., of Allegan, and B. F. Horner, M.D., of Otsego.—M. B. Beckett, M.D., *Secretary*

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BERRIEN-CASS COUNTY

"Medical Practice in Persia" was the subject of an interesting talk given by Harry Drinkman, M.D., of Ann Arbor, at the June 16 meeting held at Shady Shores, Dewey Lake. Doctor Drinkman is a former missionary to Persia where he spent four years. He discussed his experiences there and told of some of the problems with which a physician is called upon to cope.

A. F. Bliesmer, M.D., *Secretary*

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CALHOUN COUNTY

John A. Alexander, M.D., Ann Arbor was guest speaker at the meeting of June 7 held at the Marywood County Club, Battle Creek. His subject was "Pulmonary Complications, Bronchiectasis, Lung Abscess." The meeting was preceded by a golf tournament at 3:00 p. m. A demonstration of Obstetric Coöperative Service Equipment was given by nurses from the Kellogg Foundation.

Wilfrid Haughey, M.D., *Secretary*

* * *

EATON COUNTY

Election of officers was held at the June 16 meeting in Charlotte at the Carnes Tavern. The newly elected officers are President, Bert Van Ark, M.D., Eaton Rapids; Secretary, T. Wilensky, M.D., Eaton Rapids.

This is our last meeting until next fall.

Thomas Wilensky, M.D., *Secretary*

* * *

IONIA-MONTCALM COUNTY

The meeting of June 16 was held at the Michigan Department of Health Laboratories near Lansing, Dr. C. C. Young being host. Members of the Society met at the Laboratories at 2:30 p. m. and the Laboratory Staff demonstrated many of its activities which proved exceedingly interesting. A program was arranged for after dinner.

John J. McCann, M.D., *Secretary*

* * *

MONROE COUNTY

Warren Babcock, M.D., Detroit, spoke to the members of the Medical Society and the Woman's Auxiliary in Monroe on February 17. His subject was "Medical Fads and Fantasies." About sixty people were present.

John Sheldon, M.D., of the University Hospital, Ann Arbor, gave a paper on "The Diagnosis and Treatment of Asthma" at the meeting of April 21.

"State Society Night" was held on May 19 at the Monroe Country Club. Guests of the Society were H. H. Cummings, M.D., Ann Arbor, Councilor of the 14th District; Paul R. Urmston, M.D., Bay City; L. Fernald Foster, M.D., Bay City, and Wm. J. Burns of Lansing. The A.M.A. Survey was discussed and President Gelhaus appointed the following as a committee in charge of the survey in Monroe County: A. H. Reisig, M.D., L. C. Blakey, M.D., and E. C. Long, M.D.

Florence Ames, M.D., *Secretary*

* * *

MUSKEGON COUNTY

Harold Morris, M.D., Detroit, spoke to the Society at its meeting of June 17 on the subject of "Pyelitis of Pregnancy." The meeting was held at the Occidental Hotel.

L. E. Holly, M.D., *Secretary*

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OAKLAND COUNTY

Officers of the State Society were guests at the meeting of July 13, held at Orchard Lake Country Club. Mr. Wm. J. Norton of the Michigan Children's Fund and of the State Welfare Commission discussed the Welfare Reorganization Bill which will come before the voters of the state in November.

O.O. Beck, M.D., *Secretary*

* * *

ST. CLAIR COUNTY

A fish dinner and special business meeting of the society was held at the Hotel Harrington, Port Huron, on May 31.

J. H. Burley, M.D., *Secretary*

CORRESPONDENCE

The Editor, Journal of the Michigan State Medical Society

At the opening session of the American Medical Association convention in San Francisco on June 12, the delegates attended a preview of "Men of Medicine: 1938," a twenty-minute MARCH OF TIME film narrative on medical science's immeasurable contribution to American life. Immediately thereafter, it was released to 11,374 theatres throughout the world and will be seen by an estimated U. S. audience of 24,000,000 people.

This is the first authentic motion picture for theatrical distribution produced with the unrestricted coöperation of the American Medical Association, the U. S. Public Health Service, and the medical departments of the U. S. Army and Navy. Already those doctors who have seen the picture in our projection room have been unanimous in their praise and approval not only of the picture's accuracy but of its potential value in bringing essential medical knowledge to the public.

No film before has told the story of the 69 great medical schools of the U. S., the 10 years of training which each doctor must undergo at a cost of nearly $15,000, the fact that U. S. doctors, in a time of depression, are today contributing $1,000,000 daily in free clinical services for the poor and distressed.

Coming at a time when actually 40,000 or more American doctors earn less than $2,000 annually, when new plans for coöperative medicine, group hospitalization, health and old age insurance and government aid are discussed on every hand, this important record of the practice of medicine, ranging from the duties of the small-town country doctor to great laboratories of internationally-known institutions, constitutes not only an important document of medical progress but an informative and educational record which every layman should see.

Sincerely yours,

Louis de Rochemont,
Producer and Publisher,
The March of Time.

June 9, 1938

WOMAN'S AUXILIARY

President—Mrs. G. C. Hicks, 1009 Wildwood Ave., Jackson, Michigan
Sec.-Treas.—Mrs. J. W. Page, 119 N. Wisner St., Jackson, Michigan
Press—Mrs. C. B. Fulkerson, 1535 Grand Ave., Kalamazoo, Michigan

Jackson County

The Woman's Auxiliary held their closing meeting for the season Tuesday evening, May 17, at the Hotel Hayes. A seven o'clock dinner was served, the members being alphabetically seated. The tables were beautifully decorated with seasonable flowers, iris and spirea predominating. Mrs. J. H. Myers, historian, read a very interesting report of the year's work. Mrs. W. H. Enders, project chairman, announced that the re-decorating of one ward room at each of Foote and Mercy Hospitals had been completed and the committee was now getting rockers for the nursery at Foote Hospital. Mrs. John Ludwick, retiring president, made note of the fact that the Auxiliary now has a membership of seventy and she hoped that Mrs. Alter, the new president, would be successful in increasing the membership to seventy-five next year, which would make it 100 per cent.

The dinner was followed by a social hour, bridge being played by most of the members.

The committee for arrangements were Mesdames John Smith, chairman, Harold Hurley, Hector Chabut, George Baker, M. D. Wertenberger, Edward Crowley and David Phillips.

ANNA HYDE SHAEFFER
Publicity Chairman

Kalamazoo County

The annual meeting of the Woman's Auxiliary was held at the home of Mrs. L. H. DeWitt on May 17.

Covers were placed for thirty-nine members and twenty-nine guests at dinner.

After the annual reports of officers and committee chairmen the following officers for next year were elected: President, Mrs. F. M. Doyle; President-elect, Mrs. R. G. Cook; Vice President, Mrs. Sherman Gregg; Secretary, Mrs. L. J. Crum; and Treasurer, Mrs. W. D. Irwin. Mrs. W. W. Lang and Mrs. F. M. Doyle were named delegates to the state convention.

Two new members were welcomed.

The later evening was spent informally.

Members of the Auxiliary and the Academy were guests of Mr. Heavey of the State Theater on May 19 at a preview of the film, The Birth of a Baby.

(MRS. HUGO) BARBARA K. AACH,
Publicity Chairman

Kent County

The Auxiliary had its annual luncheon at the Woman's City Club in Grand Rapids May 12. Mrs. Carl Snapp, the retiring president, presided. Dr. H. S. Collisi, chairman of the state advisory committee to the state auxiliary, was an honor guest and speaker. He outlined some specific ways in which the auxiliaries could be more effective.

There followed reports from the officers and committee chairmen. The group was particularly happy to know that the benevolent fund had been increased this year by $278.09. The membership chairman reported 138 paid members. Ninety-one of these subscribed to *Hygeia*.

The auxiliary expressed its thanks and appreciation to Mrs. Snapp for her leadership and devotion this year.

Mrs. Henry Pyle, chairman of the nominating committee, presented the slate of nominations and new officers and committee heads as follows were elected:

President	Mrs. Wm. Butler
Vice President	Mrs. J. B. Whinery
Secretary	Mrs. Robert M. Eaton
Treasurer	Mrs. Harold Robinson
Corresponding Secretary	Mrs. Lucian Griffith
President-Elect	Mrs. Lynn Ferguson

Committee Heads

Program	Mrs. Leon De Vel
Membership	Mrs. R. G. Laird
Social	Mrs. H. S. Collisi
Hygeia	Mrs. Guy De Boer
Press	Mrs. Charles Frantz
Courtesy	Mrs. Leon Bosch
Legislative	Mrs. L. M. McKinlay
Public Relations	Mrs. Fred P. Currier
Philanthropic and Welfare	Mrs. J. C. Tiffany
Revision	Mrs. Henry J. Pyle
House	Mrs. A. J. Baker
Historian	Mrs. A. V. Wenger

(MRS. ROBERT M.) MIRIAM ADAMS EATON,
Press Chairman.

Monroe County

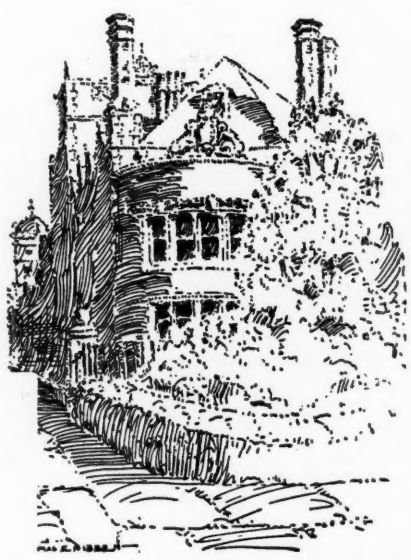
The Auxiliary had its April meeting a buffet supper, in honor of the state president-elect, Mrs. P. R. Urmston. Mrs. W. W. Bond, our local president-elect, was hostess, and twenty-five guests were present. Mrs. L. F. Foster, a member of the Bay City Auxiliary, was also a special guest.

(MRS. VINCENT) MARTHA BARKER

Tuscola County

A new Auxiliary was organized on May 12 with eleven members, and plans for next year were discussed with enthusiasm. A joint meeting with the Tuscola County Medical Society will be held in June.

MRS. L. C. SAVAGE, *Secretary.*



MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner

LANSING, MICHIGAN

THE DEPARTMENT OF HEALTH AND HEALTH EDUCATION

The transition of the health department program during the past three or four decades from one of environmental sanitation, quarantine and law enforcement to its present broad educational scope has come about through the realization that the health of the people depends not solely upon what has been done for or to them, but principally upon what people do for themselves, declared Dr. Don W. Gudakunst, State Health Commissioner, in addressing the recent School Health Education Institute at Ann Arbor.

This transition has not been an easy one to make, for people could not readily give up their concept of actual or implied threat at the mention of a board of health. Then, too, this new educational program was met by the challenge that each of us is inclined to think we are natural-born teachers—that we are competent to enter the field of health education. Yet a survey of persons engaged in health education today indicates that they are drawn from all walks of life save that of education.

Teaching as a profession is a science and an art. An educational task is no less difficult because we define it by the modifying term "health education." Our difficulties are only increased by this specialization. There is nothing in the prescribed academic training of physician, nurse or engineer that gives that person any insight in the learning processes of people, nor does such training afford any mastery over the methods to be utilized in teaching.

I have listened to school doctors talk to parents. They were more prone to order than to teach. I have heard sanitary inspectors attempt to gain their point by insisting the public "must" because it was the law. I have heard health officer after health officer defend this as education and claim this was part and parcel of a health education program. We must be certain, therefore, that the members of our staff have some knowledge of and abilities in teaching before they undertake the rôle of educator.

We have long felt the need for this type of educational health program, but we have not been able to do any too much about it. There are, however, several points which can be considered by any health department in conducting its health education program. Answers to the following questions are fundamental: 1. What needs to be taught? 2. Who needs to be taught? 3. Can those selected learn the lesson we attempt to teach and can they alter their behavior if they do learn? 4. How can they learn and what are their learning processes? 5. Who can best teach this lesson? and 6. How should it be taught?

We must first find what is our greatest need that can be met. This need in most instances is, of course, not universal. Not all people need to be taught all the points of health. Health education must be selective, directed and purposeful.

Next we must consider whether the unhealthy situation can be remedied by education. With many of the diseases we are totally at a loss, for we have no real remedy. For example, we have been teaching the prevention of colds. To the best of our knowledge there is no prevention. There is no

decrease in incidence as the result of talking. Our desires outpace our abilities to control.

Our programs of health education must be directed to those who need education; they must be pertinent in point of place, time and subject matter. Then next we must consider the very important fact as to whether our educational endeavors can result in altered human behavior. If we cannot see our way clear to carry an educational program through to the point of altering behavior, then it is better never to start in the first place.

How should we teach health? I am only too free to admit I do not know. That we must teach is admitted by all—this is the salvation of public health. Our very existence depends upon our abilities as teachers. We are learning, but slowly. Only a beginning has been made, and much that is wrong has been done: much, too, that is good. But we have not given sufficient thought to why it was good or why it was wrong. My plea is to study ourselves. Let us be most critical. Let us learn first before we attempt to teach.

* * *

PUBLIC HEALTH CONFERENCE TO BE HELD AT GRAND RAPIDS

The Michigan Public Health Conference, long held in Lansing, will be transferred to Grand Rapids for its eighteenth annual sessions Nov. 9, 10 and 11, it has been decided by the Board of Directors of the Michigan Public Health Association and the State Health Commissioner. Conference headquarters will be at the Pantlind Hotel and general sessions will be held in the Grand Rapids Civic Auditorium.

The conferences are sponsored jointly by the Michigan Department of Health and the Michigan Public Health Association. Organizations meeting in conjunction with the conference include the Michigan Association of Sanitarians, the State Organization for Public Health Nursing and the Michigan School Health Association. More than 1,200 health workers were registered at the 1937 conference.

* * *

PUBLIC HEALTH GRANTS UNDER SOCIAL SECURITY ACT

Michigan's public health grant-in-aid for the fiscal year beginning July 1, 1938, under the terms of the Federal Social Security Act will total $369,399.70, the Michigan Department of Health has been notified.

Of this total, $260,399.00 has been alloted to Michigan by the U. S. Public Health Service under the terms of Title VI of the Social Security Act "for the purpose of assisting states, counties, health districts, and other political subdivisions of the states in establishing and maintaining adequate public health services, including the training of personnel for state and local health work." This is a decrease from the $292,732.00 received during the past fiscal year.

From the Children's Bureau under the provisions of Title V of the Social Security Act, the Michigan Department of Health will receive during the next fiscal year a total of $109,000.70 for the development and maintenance of services for promoting the health of mothers and children. A total of $99,103.76 was received for this purpose during the 1937-38 fiscal year.

* * *

SEROLOGIC TESTS ON MARRIAGE LICENSE APPLICATIONS

During the first six months of operation of Michigan's Antenuptial Physical Examination Law (Act 207, P.A. 1937), a total of 292 positive serologic tests

for syphilis have been reported by the laboratories of the Michigan Department of Health and the qualified registered laboratories of the state. Twenty-six doubtful tests were also reported during this period.

The Department laboratories made a total of 12,177 serologic tests, of which 166 were positive and 24 doubtful. Approximately 1.4 per cent of all the tests showed positive indications of syphilis. The total number of tests made by the registered laboratories is not available.

A record of violations and complaints concerning this law is being maintained by the Michigan Department of Health for reference in formulating proposed changes in the present law. Reports from physicians and health officers of violations or pertinent observations on the administration of the Antenuptial Physical Examination Law will be welcomed by the Department.

* * *

SYPHILIS TREATMENT OUTLINES FOR PHYSICIANS

The Advisory Committee on Syphilis Control of the Michigan State Medical Society has prepared pamphlets on "Suggested Outlines for the Treatment of Syphilis" and "Syphilis Treatment Tech-especially for physicians treating syphilis two nic, Complications and Reactions."

These pamphlets have been published by the Michigan Department of Health and will be sent free to any physician upon request. The suggested outlines include recommended treatment schedules which are in accord with the considered opinion of leading syphilologists. The treatment schedules may be applied with drugs similar to those supplied by the Michigan Department of Health. General directions for preparation and injection of arsenicals are presented in "Syphilis Treatment Technic, Complications and Reactions" as well as a description of possible immediate and delayed reactions or complications.

* * *

UNIFORM SANITARY REGULATIONS

The Michigan Department of Health is coöperating with the Bureau of Foods and Standards of the State Department of Agriculture and the State Liquor Control Commission in the formulation of uniform rules and regulations for the control of all establishments where food or drink is manufactured, handled, prepared, stored or served.

Special regulations will apply to establishments where only food is served and to establishments where beer, wine or liquor are served. The regulations will be posted in all food establishments. The printed regulations are expected to be available before the opening of the summer resort season. Sanitarians of local health departments may be deputized by the Bureau of Foods and Standards for the enforcement of these rules and regulations.

* * *

FEDERAL SYPHILIS PROGRAM

The Michigan Department of Health will receive $77,000 from the U. S. Public Health Service during the next fiscal year to finance syphilis control activities in this state as part of the $3,000,000 national syphilis program proposed under the recently-enacted LaFollette-Bulwinkle bill, the State Health Commissioner has been notified.

These funds will make possible more extensive and conveniently located laboratory facilities for the diagnosis of syphilis, state-wide free distribution of antisyphilitic drugs to physicians, lay and profession-

al educational activities, follow-up of infectious cases and sources of infection, and treatment of indigent cases.

* * *

PERSONNEL CHANGES

Dr. M. B. Beckett has resigned as director of the Allegan County Health Department to become district director of the W. K. Kellogg Foundation program in Allegan and Van Buren counties. Dr. James A. Dolce will succeed Dr. Beckett as director of the Allegan County Health Department. Dr. T. E. Gibson, former health officer of Eaton County, is now director of the Van Buren County Health Department, succeeding Dr. Frank Carroll.

Dr. C. D. Barrett, former director of the Bureau of Communicable Diseases, Michigan Department of Health, is directing the recently-organized Ingham County Health Department and the Michigan Training Center at Mason. Dr. Richard Sears is directing the activities of the Muskegon County Health Department during the absence of Dr. R. J. Harrington.

Dr. R. T. Westman, director of the Bay County Health Department, with headquarters at Bay City, has resigned, effective July 1. Dr. F. J. Austin has also resigned as director of the Houghton-Keweenaw Health Department as of July 1.

* * *

AUTOMOBILE FATALITIES DECREASING

Deaths due to automobile accidents in Michigan appear finally to have reached the peak of their steady increase during the past decade. During the early months of 1938 there has been a 41 per cent decline in mortality on Michigan's highways.

A total of 354 deaths were recorded during the first four months of the year, compared with 601 during the same period in 1937. There were 115 automobile deaths in January this year, 72 in February, 81 in March and 86 in April. Michigan's vigorous education, licensing and law enforcement campaign during the past six months has brought results in that this state is ranked among the leaders in the national campaign to reduce mortality from this cause.

General News and Announcements

THE ONE HUNDRED PER CENT CLUB OF THE MICHIGAN STATE MEDICAL SOCIETY

1. Barry County Medical Society
2. Cass County Medical Society
3. Chippewa-Mackinac County Medical Society
4. Clinton County Medical Society
5. Delta County Medical Society
6. Dickinson-Iron County Medical Society
7. Eaton County Medical Society
8. Gogebic County Medical Society
9. Hillsdale County Medical Society
10. Houghton-Baraga-Keweenaw County Medical Society
11. Ingham County Medical Society
12. Jackson County Medical Society
13. Lapeer County Medical Society
14. Lenawee County Medical Society
15. Livingston County Medical Society
16. Luce County Medical Society
17. Manistee County Medical Society
18. Mecosta-Osceola County Medical Society
19. Menominee County Medical Society
20. Midland County Medical Society
21. Muskegon County Medical Society
22. Newago County Medical Society
23. O.M.C.O.R.O. County Medical Society
24. Oceana County Medical Society
25. Ontonagon County Medical Society
26. Ottawa County Medical Society
27. Saginaw County Medical Society
28. St. Clair County Medical Society
29. Schoolcraft County Medical Society
30. Shiawassee County Medical Society
31. Tuscola County Medical Society
32. Wexford-Kalkaska-Missaukee County Medical Society

The list of county medical societies which have recorded 100 per cent paid membership for the year 1938 is growing. Is your society listed above? Several societies have reported dues for all their members except one or two. If your dues are still unpaid, please contact your county secretary today; you may be able to put your society in the 100 per cent classification.

"Make new friends, retain the old,
The former are silver, the latter are gold."

L. J. G., Detroit.

* * *

President Henry Cook addressed the School Health Education Institute in Ann Arbor on May 27. His subject was "The Place of the physician on the school health program."

* * *

Word has just been received of the death, on June 1, 1938, of Macomb G. Foster of the firm Fairchild Bros. and Foster of New York City. Our sincere sympathy is extended to the family.

* * *

If you know of a community where a young physician might locate, please contact the Placement Bureau, 2020 Olds Tower, Lansing. A number of physicians who have just finished their interneship are looking for available openings.

* * *

"What Everyone Should Know About Cancer"—a booklet prepared in 1938 by the Michigan State Medical Society Cancer Committee—was mailed to each member of the State Society in June. Additional copies may be secured by writing the Executive Office, 2020 Olds Tower, Lansing.

* * *

At the funeral services for Mervin Tomlin of Port Huron, member of the Michigan Legislature, Councilor T. F. Heavenrich, M.D., and J. H. Burley, M.D., of Port Huron, represented the Michigan State Medical Society and the St. Clair County Medical Society.

"Does your firm advertise in THE JOURNAL of the Michigan State Medical Society?" or "Do you have an exhibit at the Detroit Convention next September?" should be questions asked by you of every detail man who seeks your patronage.

Patronize those who support you.

* * *

Safe! All products advertised on the pages of THE JOURNAL of the Michigan State Medical Society have been tested and approved. They are safe for you to use and prescribe. Don't take a chance and prescribe untested, and perhaps dangerous drugs. Patronize firms who advertise their tested and approved products in THE JOURNAL.

* * *

Dr. Christopher J. Stringer began his duties in May as superintendent and medical director of the Ingham County Tuberculosis Sanatorium, replacing Dr. George C. Stucky, who had held the position since 1925. Dr. Stringer was graduated from the University of Iowa in 1931, and has been at the Herman Kiefer Hospital in Detroit for several years.

* * *

The Missouri Medical Association's House of Delegates, at its 1938 annual meeting, passed the following resolution: "The Basic Science Law is fair and impartial. It is progressive legislation, designed to meet modern needs. Your committee recommends that the Committee on Public Policy be directed to introduce a Basic Science Act in the 1939 session of the state legislature."

* * *

An amendment to the Social Security Act, namely, Bill No. S3541, embodying a rehabilitation program for tuberculosis, has been introduced into the Senate, and, if passed, will take effect on July 1. Three million dollars for the first year, four million the second, and five million thereafter for each year, will be set aside to provide for the cost of living expenses and a period of training.

* * *

Dr. William Donald of Detroit has taken a very keen and intelligent interest in the medical department of the Detroit Public Library. His latest venture is a non-medical corner of the medical library which consists of books by doctors written by doctors on non-medical subjects, a sort of leisure hour department. Dr. Donald reports recent contributions to the number of twenty-three.

* * *

Let's go out to the ball game! The Detroit Tigers will be at home in Detroit prior to, during, and immediately after the 1938 Detroit Convention of the Michigan State Medical Society next September:

September 15, 16, 17—playing New York
September 18, 19—playing Washington
September 20, 21—playing Philadelphia
September 22, 23, 24, 25—playing Cleveland.

* * *

The Public Health Committee of the Detroit Chamber of Commerce has invited Dr. Bruce H. Douglas, president of the Michigan Tuberculosis Association, to make a survey in Hawaii of conditions for the control of tuberculosis. The Detroit Public Health Committee is working in coöperation with the Territorial Health Department, the Council of Social Agencies, the Territorial Medical Society and other interested groups. Dr. Douglas sailed for Hawaii in June and expects to return in August.

Hotel reservations should be obtained early if you are planning to attend the 1938 Detroit convention next September. A record-breaking attendance is being planned for and choice hotel accommodations will be taken fast. Plan now to be a part of the greatest convention in the history of the Michigan State Medical Society. Remember the dates: September 20, 21, 22, 1938; the place: The Book-Cadillac Hotel, Detroit.

* * *

Recovery—or Deeper Depression?—The answer is up to YOU. Next November 8, 435 United States representatives and some 32 U. S. Senators, as well as 132 Michigan legislators, will be elected—by you. All who are engaged in business enterprises, small as well as large, must be *actively* concerned in the election this year.

It's up to you to sweep in Recovery on election day—with your vote.

* * *

A physician is wise to carry personal liability insurance on automobiles for larger sums than the average member of society. The reasons are that the danger of a very large judgment is a real one, and the cost of the extra coverage is relatively small. One can double the coverage for as little as fifteen per cent additional. This protection is important if one were so unfortunate as, in a recent case, to run into a busload of people and injure a number of them.

* * *

Please certify to the Executive Office, 2020 Olds Tower, Lansing, at least thirty days in advance of the annual meeting (no later than August 19), the names of any of your members for whom Honorary, Retired, Emeritus or Associate Membership in the State Society will be sought next September. The membership records of physicians, recommended by county medical societies for special memberships, must be checked before final submission to the House of Delegates.

* * *

Crippled and Afflicted Child Commitments for May, 1938, were as follows: Crippled Children: total cases, 376, of which 112 went to University Hospital and 254 went to miscellaneous hospitals. Of the above, Wayne County sent 82 to hospitals of which 9 went to University Hospital and 73 went to miscellaneous hospitals.

Afflicted Children: Total cases 1,998 of which 266 went to University Hospital and 1,732 went to miscellaneous hospitals. Of the above, Wayne County sent 553 to hospitals, of which 32 went to University Hospital and 521 went to miscellaneous hospitals.

* * *

A "Preventive Medicine Reunion" will be held at the Book-Cadillac Hotel, Detroit, September 21, 1938, with a luncheon. All those members of the Preventive Medicine Committee during former years are especially invited and urged to attend this luncheon. All others who are interested in preventive medicine are cordially invited to attend.

The speaker will be John Gordon, M.D., of Boston, who has recently spent considerable time in Roumania. His subject will be "Highlights of Rural Roumanian Medicine." Plan now to attend this outstanding attraction.

* * *

Dr. Gaylord S. Bates of Detroit has succeeded Dr. David Sugar as editor of the *Detroit Medical News*. Dr. Sugar has been editor of the *Medical News* for four years, during which time he has very ably revived the idea of journalism with a personality. Dr. Sugar's editorial page has been clear, virile, and entertaining. He has proved himself a master in the writing of quotable paragraphs. He

has served the Wayne County Medical Society well and has the sincere gratitude of all its members. The arduous duties of editor so ably performed by Dr. Sugar will now, as mentioned, be the work of Dr. Gaylord S. Bates, who, while new, possesses the personal qualities and mental equipment that will enable him to carry on the torch so brilliantly lighted by his predecessors. Dr. Bates received his academic education at Hiram College in Ohio. From there he attended Harvard University Medical School, where he was graduated in 1928. Following his graduation, he spent four years' surgical internship at Harper Hospital, Detroit. Following his internship at Harper, Dr. Bates was associated with Dr. Hugo Freund of Detroit. His practice is confined to surgery and he is now located in the David Whitney Building. He is a Fellow of the American College of Surgeons. THE JOURNAL wishes Dr. Bates every success in his new venture.

* * *

The working man, who must be very conscientious and careful about his budget these days, feels that medical service deserves to be placed in the family budget ahead of luxuries. He is aghast at the figures of the annual expenditure per average family for luxuries.

Passenger automobiles	$150.00
Tobacco	67.00
Gasoline (non-commercial)	37.00
Candy	37.00
Movies and entertainment	35.00
Soda waters, ice cream and gum	34.00
Jewelry and furs	29.00
Liquor (Michigan, 1935)	22.00
Radios and musical instruments	16.00
Cosmetics	15.00
	$442.00

* * *

Are your indigent patients being granted necessary medical care? If not, start educating your local welfare authorities who are charged with the legal and financial responsibility of supplying this necessity to wards of the county. If medical care of indigents is not allowed, or if it is the first item eliminated when a welfare budget is curtailed, the blame is placed—not on the constituted authorities who control the situation—but on the physicians. The resulting cry is for State Medicine with salaried doctors!

Start educating your welfare authorities that medical care is a necessary commodity, like food, clothing, or shelter, or fuel; that often, proper medical care at the right time—rehabilitation—permits a man to obtain employment and get off the dole. This is *your* responsibility: Education.

* * *

"The Doctor" now in a permanent home. The $150,000 reproduction of the Sir Luke Fildes masterpiece "The Doctor" first shown by the Petrolagar Laboratories at Chicago's Century of Progress Exposition in 1933, was recently presented by its owners to the new Rosenwald Museum of Science and Industry in that city.

Following the two World's Fairs, "The Doctor" exhibit went on a tour of 50,000 miles and was viewed by over five million people in eighteen principal cities throughout the country. Designed to remind the public of the importance of the family physician, it required the full time of the late Chicago sculptor, John Paudling and the noted artist Rudolph Ingerle and a large corps of assistants, and took nearly a year to complete. In its new location in the Rosenwald Museum it will be seen by millions of visitors annually.

* * *

Blind and Deaf Children.—The educational program in the state for both the blind and the deaf groups is greatly handicapped by lack of an early

census of these children. In order to be of service to the parents of the blind child in preventing "blindisms" and queer personality developments, the State Department of Public Instruction wishes to be informed of each child at the earliest possible moment. In the case of the deaf, diagnosis is of course more difficult, but special training should be started in the home as early as three years of age. Otherwise these children grow up to school age without having developed any conception of language. A system of reporting the blind and the deaf children on identification is a highly desirable service. Please supply the names of such cases to your local school authorities, or to the State Department of Public Instruction, Lansing.

* * *

B. R. Corbus, M.D. of Grand Rapids was re-elected as chairman of the Joint Committee on Health Education at its meeting at the Michigan Union, Ann Arbor, on June 2. The Joint Committee is composed of representatives of the following organizations:

Michigan State Medical Society
Michigan Department of Health
Michigan Public Health Association
Michigan Hospital Association
Michigan Tuberculosis Association
Michigan State Nurses Association
Michigan State College
University of Michigan
Michigan Division, American Red Cross
Wayne County Medical Society
State Conference of Social Work
Probate Judges Association of Michigan
Woman's Organization for Non-Partisan Reform
Michigan Education Association
Michigan State Dental Society
Michigan Association of School Physicians
Michigan Association of Sanitarians
Michigan Congress of Parents and Teachers
Michigan State Federation of Women's Clubs
Michigan Home Economics Association
Michigan Physical Education Association
Wayne University College of Medicine and Surgery
State Department of Public Instruction
Children's Fund of Michigan
W. K. Kellogg Foundation
Horace H. and Mary A. Rackham Fund
McGregor Fund

Costs of public relief in April continued the rise recorded for the six preceding months, according to figures issued today by the Social Security Board. Total federal, state and local costs incurred for aid to the needy in April, including earnings under the Works Program, amounted to $242,931,000, an increase of $7,772,000, or a little more than 3 per cent, over the total for March.

Figures reported by the Board are compiled regularly in collaboration with other Federal agencies and state and local authorities. The April figure includes amounts for the various programs as follows: Public assistance to the needy aged, to the needy blind, and to dependent children from federal, state, and local funds under the Social Security Act, and other public assistance of these special types, $41,522,000; earnings under the Works Program, including the Works Progress Administration and other federal agencies through which wages were paid to persons certified as in need of relief, $139,209,000; Civilian Conservation Corps, $18,311,000; subsistence grants under the Farm Security Administration, $2,336,000; general relief in cash and in kind, by states and localities, $41,553,000. These sums represent substantially all public aid received by the needy, with the exception of aid to transients. Administrative costs are not included.

On the basis of reports received by the Board it was estimated, after allowance for duplications, that in April approximately 6.4 million different households, probably comprising about 20 million persons, received public aid of one or more of the types mentioned above. As compared with March, there was an increase of less than 2 per cent in the number of different households in receipt of public aid.

According to reports from states coöperating in public assistance programs under the Social Security Act, costs of $40,636,658 were incurred in April for payments from federal, state, and local funds to recipients of old-age assistance, aid to the blind, and aid to dependent children. In April there were 1,671,223 recipients of old-age assistance in forty-seven states, the District of Columbia, Alaska,

and Hawaii, comprising approximately 21 per cent of the estimated population aged 65 and over. The average payment per recipient was $19.29 for that month, ranging from $4.65 in Mississippi to $32.53 in California. In 36 states, Hawaii, and the District of Columbia, making payments under the program for April, aid was extended to 37,263 blind persons. The average payment for the month was $23.53. In 38 states, the District of Columbia, and Hawaii, aid was provided for April on behalf of 586,293 dependent children in 236,791 families. The average monthly payment was $31.76 per family.

* * *

UPPER PENINSULA MEDICAL SOCIETY

Sault Ste. Marie, Michigan

PROGRAM

Thursday, August 18, 1938

Morning

Welcome Address—Honorable Paul Adams, Mayor, Sault Ste. Marie

Addresses—W. T. King, M.D., President, Upper Peninsula Medical Society
Don W. Gudakunst, M.D., State Health Commissioner
L. O. Geib, M.D., Chairman, Preventive Medicine Committee, Michigan State Medical Society.
L. Fernald Foster, M.D., Secretary, M.S.M.S.
Wm. J. Burns, LL.B., Executive Secretary, M.S.M.S.

Luncheon

Afternoon

"Peripheral Vascular Diseases—with Special Reference to Varicose Ulcers and Varicose Veins"—Walter G. Maddock, M.D., Ann Arbor

"Back Pain"—Carl E. Badgley, M.D., Ann Arbor

"Nephritis and Pyelonephritis"—Floyd H. Lashmet, M.D., Petoskey

Evening

Banquet—6:30 p. m., Objibwa Hotel.

"A Doctor's Inventory"—James D. Bruce, M.D., Ann Arbor, Director of Postgraduate Medical Education, University of Michigan.

Friday, August 19, 1938

Morning

"Fracture of the Long Bones"—Carl E. Badgley, M.D., Ann Arbor

"The Relationship of County Health Units to the Profession"—W. W. Bauer, M.D., Director of Bureau of Health and Public Instruction, American Medical Association, Chicago

"Management of Gall Bladder Disease"—Walter G. Maddock, M.D., Ann Arbor

IN MEMORIAM

Dr. David R. Clark

Dr. David R. Clark, a physician and psychiatrist in Detroit for thirty years, died July 3, 1938, following an operation for abdominal tumor. Dr. Clark was born in Port Clinton, Ohio, on January 26, 1874. He attended school in Port Clinton and Ann Arbor, and was graduated from the University of Michigan Medical School in 1895. After graduation he began general practice in Niles, Michigan, and after three years he came to Detroit. Dr. Clark was head of the psychopathic department of Receiving Hospital and senior medical officer at St. Joseph's Retreat. Dr. Clark was vitally interested in the care of mental patients and alcoholics and advocated many reforms. Dr. Clark was a past president of the Detroit Society of Psychiatry and past president of the Receiving Hospital staff. He was a member of the Wayne County and the Michigan State Medical Societies, the American Medical Association, the American Psychiatric Association and the American College of Physicians. He also belonged to the Dearborn Country Club and the Au Sable Club. Dr. Clark leaves his wife, Mrs. Glen M. Clark; a son, David R.; a daughter, Mary Jane; and a brother, Dr. George R. Clark, a Detroit dentist.

Dr. R. E. Cumming

Dr. Robert Effinger Cumming of Detroit died Thursday, June 23, 1938. Dr. Cumming was one of Detroit's outstanding surgeons for seventeen years. He was born in Staunton, Virginia, on August 7, 1894, and attended the Hampdon-Sydney College of Virginia, Kentucky Wesleyan College, University of Louisville, Columbia University and the Army Medical School. In 1917, he began to specialize in surgery in the United States Army, and from 1919 to 1921 served as chief of the genito-urinary surgery department of the Walter Reed Hospital in Washington. Following this, he came to Detroit, where he later became a member of the surgical staff of Receiving Hospital, Grace Hospital, St. Joseph's Mercy Hospital and the Charles Godwin Jennings Hospital. Dr. Cumming was a fellow of the American College of Surgeons, a member of the American Urological Association, the Wayne County Medical Society, the Michigan State and American Medical Associations. In 1934, he was president of the North Central Branch of the urological association, and also served as president of the Detroit branch. Dr. Cumming was active in church work in Detroit, where he was an elder in the First Presbyterian Church. He also held membership in various local clubs, including the St. Andrew's Society, the Detroit Country Club, the Detroit Club, Detroit Boat Club, Indian Village Club and the Fine Arts Society. Dr. Cummings leaves his wife, the former Pauline D. Anderson of Richmond, Virginia, and one daughter, Carolyn, seventeen years old. He is also survived by five brothers, William K., of Benton, Md.; Daniel J., of Mokpo, Korea; Bruce A., of Kwangju, Korea; and Colin and Dr. Richard C., of Ocala, Fla.; and a sister, Miss Lucy Cumming, of Ocala, Florida.

Dr. Charles J. Ennis

Sault Ste Marie has lost her oldest physician in the death of Dr. C. J. Ennis who died on June 11 at

the advanced age of eighty-seven years. Dr. Ennis had lived at the Sault for fifty-four years. He was born August 30, 1850, at Dublin, Ireland. He attended Belvidere College and the Carmichael School of Medicine, and graduated from the College of Surgeons at Dublin in 1874. Following his graduation, he visited a number of British colonies as physician including the great convict settlement in Perth, Australia. On his way to the Far East, he arrived at the Sault where he made up his mind to go no farther. He resigned the colonial service and settled down to practice in the American town. About this time, he married Miss Lydia Cunningham, whom he met in Buffalo. She died in 1927. There were no children.

Dr. Ennis organized the first medical society in Sault St. Marie and served a number of terms as head of the society. He was also active in civic affairs. Dr. Ennis' Irish wit and talent made him very popular as an after-dinner speaker, and many times he filled the rôle of toastmaster.

The *Evening News* of Sault St. Marie commented on his democratic spirit and service to his community as follows: "In the recording angel's great book the name of Dr. Charles J. Ennis, no doubt, stands high among the names of those who loved their fellow men. God may have a special niche reserved for country doctors, but if we are right in estimating Dr. Ennis' love for companionship, friendship and unselfish service, his spirit will soon be hob-nobbing with the spirits of Tom, Dick and Harry in heaven as he did on earth. . . . He was an institution in Sault Ste. Marie. He belonged to another age, but life never passed him by. That bright twinkle in his eye never dimmed, that Irish wit always thrilled to life and the joy of living, and that disregard for self always kept him up front." Dr. Ennis was a member of the Chippewa County, Michigan State and American Medical Associations.

Dr. Robert Carl Humphrey

Dr. Robert Carl Humphrey of Detroit died recently. He was born December 23, 1907, in Detroit, and received his education in local institutions. He was graduated from the Wayne University Medical School and interned at Receiving Hospital. Later he became a resident physician at the Wyandotte General Hospital and followed this by entering general practice. At the beginning of this year he became a staff physician at the Lapeer Home and Training School. Dr. Humphry was a member of the Wayne County and Michigan State Medical Societies, the American Medical Association and Nu Sigma Nu fraternity. He is survived by his wife, Mrs. Alma Humphry, his parents and two sisters.

The Memory of Dr. Manwaring Honored

On February 13, 1938, the members of the Genessee County Medical Society, including the staff of the Hurley Hospital, assembled to witness the presentation of the plaque by the board of management of Hurley Hospital in appreciation of the gift of the library of the late Dr. J. G. R. Manwaring to the hospital. The wording of the plaque is:

In Memory of
J. G. R. Manwaring
Physician, Surgeon
Teacher—1877-1935

Addresses were made by Dr. W. A. Marshall who took as his subject, "Dr. Manwaring, the Physician," and Dr. H. E. Randall, who spoke on "Dr. Manwaring, the Surgeon." Dr. A. McArthur, president of the Genessee County Medical Society, presided and Dr. F. E. Reeder accepted the plaque on behalf of the hospital. The addresses of Dr. Marshall, Dr. Randall and Dr. Reeder, which are too long to reproduce here, are splendid expressions of tribute to the memory of one of their colleagues who had accomplished so much in a life that was cut short in its prime.

PROFESSIONAL ANNOUNCEMENTS

COUNTY SOCIETIES

BRANCHES OF THE MICHIGAN STATE MEDICAL SOCIETY

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING	
			Regular	Annual
Allegan	E. T. BRUNSON Ganges	M. B. BECKETT Allegan	1st Tuesday	1st Tuesday December
Alpena-Alcona-Presque Isle	W. E. NESBITT Alpena	HAROLD KESSLER Alpena	Last Thursday 6:00 p. m.	Last Thursday December
Barry	G. F. FISHER Hastings	THOMAS H. COBB Woodland	2nd Thursday 8:00 p. m.	1st Thursday January
Bay-Arenac-Iosco-Gladwin	C. L. HESS Bay City	A. L. ZILIAK Bay City	2nd and 4th Wednesday (except July, Aug., Sept.) 6:00 p. m.	2nd Wednesday December
Berrien	HARRY KOK Benton Harbor	A. F. BLIESMER St. Joseph	2nd Wednesday or Thursday	2nd Wednesday or Thursday, December
Branch	N. S. ALDRICH Coldwater	F. S. LEEDER Coldwater	3rd Thursday 6:30 p. m.	3rd Thursday December
Calhoun	J. E. ROSENFELD Battle Creek	WILFRID HAUGHEY Battle Creek	1st Tuesday (except July and Aug.)	1st Tuesday December
Cass	K. C. PIERCE Dowagiac	GEO. LOUPEE Dowagiac	2nd Wednesday or Thursday	December 15
Chippewa-Mackinac	J. F. DARBY St. Ignace	DWIGHT F. SCOTT Sault Ste. Marie	1st Thursday 7:30 p. m.	1st Thursday December
Clinton	F. E. LUTON St. Johns	T. Y. HO St. Johns	Last Tuesday (Oct. to June, incl.)	Last Tuesday October
Delta	W. A. LEMIRE Escanaba	G. W. BENSON Escanaba	1st Thursday 8:30 p. m.	December 2
Dickinson-Iron	L. E. IRVINE Iron River	W. H. HURON Iron Mountain	1st Thursday 6:30 p. m.	1st Thursday December
Eaton	H. A. MOYER Charlotte	THOMAS WILENSKY Eaton Rapids	3rd Thursday	No set date
Genesee	A. McARTHUR Flint	C. W. COLWELL Flint	2nd and 4th Tuesday (except July and August)	2nd Tuesday November
Gogebic	CHAS. E. ANDERSON Bessemer	WM. H. WACEK Ironwood	3rd Tuesday	3rd Tuesday December
Grand Traverse-Leelanau-Benzie	MARK OSTERLIN Traverse City	C. E. LEMEN Traverse City	1st Tuesday 8:00 p. m.	1st Tuesday December
Gratiot-Isabella-Clare	C. M. BASKERVILLE Mt. Pleasant	RICHARD L. WAGGONER St. Louis	3rd Thursday	3rd Thursday December
Hillsdale	W. E. ALLEGER Pittsford	E. G. McGAVRAN Hillsdale	Last Thursday	Last Thursday December
Houghton-Baraga-Keweenaw	R. S. BUCKLAND Baraga	C. A. COOPER Hancock	1st Tuesday	1st Tuesday January
Huron-Sanilac	R. R. GETTEL Kinde	E. W. BLANCHARD Deckerville	2nd Thursday	2nd Thursday December
Ingham	DANA M. SNELL Lansing	R. J. HIMMELBERGER Lansing	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Ionia-Montcalm	R. R. WHITTEN Ionia	JOHN J. McCANN Ionia	2nd Tuesday 7:00 p. m.	2nd Tuesday December
Jackson	JOHN VAN SCHOICK Hanover	H. W. PORTER Jackson	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Kalamazoo-Van Buren	R. J. HUBBELL Kalamazoo	L. W. GERSTNER Kalamazoo	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Kent	A. J. BAKER Grand Rapids	J. M. WHALEN Grand Rapids	2nd and 4th Wednesday 8:15 p. m.	2nd Wednesday December
Lapeer	G. C. BISHOP Almont	C. C. JACKSON Imlay City	2nd Thursday	December or January
Lenawee	CHAD A. VAN DUSEN Blissfield	ESLI T. MORDEN Adrian	3rd Tuesday	3rd Tuesday October
Livingston	BERNARD H. GLENN Fowlerville	DUNCAN C. STEPHENS Howell	1st Friday 6:30 p. m.	1st Friday December
Luce	A. T. REHN Newberry	C. D. HART Newberry	1st Tuesday 8:00 p. m.	1st Tuesday December
Macomb	JOSEPH N. SCHER Mt. Clemens	R. F. SALOT Mt. Clemens	1st Monday 12:00 noon	1st Monday December
Manistee	KATHRYN BRYAN Manistee	C. L. GRANT Manistee	Every Monday noon	1st Monday December
Marquette-Alger	N. J. McCANN Ishpeming	D. P. HORNBOGEN Marquette	No set date	December
Mason	V. J. BLANCHETTE Custer	CHAS A. PAUKSTIS Ludington	2nd Tuesday	2nd Tuesday December
Mecosta-Osceola	L. F. CHESS Reed City	GLENN GRIEVE Big Rapids	2nd Tuesday	2nd Tuesday December

COUNTY SOCIETIES

Menominee	JOHN TOWEY Powers	WM. S. JONES Menominee	3rd Thursday	3rd Thursday December
Midland	CHAS. L. MacCALLUM Midland	N. C. GREWE Midland	2nd Thursday	2nd Thursday December
Monroe	W. J. GELHAUS Monroe	FLORENCE AMES Monroe	3rd Thursday (except July and Aug.)	3rd Thursday October
Muskegon	CHAS. A. TEIFER Muskegon	L. E. HOLLY Muskegon	Last Friday 6:00 p. m.	2nd Friday December
Newaygo	LAMBERT GEERLINGS Fremont	W. H. BARNUM Fremont	As called	3rd Tuesday December
Northern Mich. (Antrim.- Charlevoix- Emmet- Cheboygan)	B. H. VANLEUVEN Petoskey	W. E. LARSON Levering	2nd Thursday 6:00 p. m.	2nd Thursday December
Oakland	AARON RIKER Pontiac	O. O. BECK Birmingham	1st Wednesday (except July and Aug.)	1st Wednesday December
Oceana	MERLE G. WOOD Hart	N. W. HEYSETT Hart	No definite date set	December
O.M.C.O.R.O. (Otsego- Montmorency- Crawford-Oscoda- Roscommon- Ogemaw)	LEVI A. HARRIS Gaylord	C. G. CLIPPERT Grayling	On call	December
Ontonagon	F. W. McHUGH Ontonagon	E. J. EVANS Ontonagon	On call	January
Ottawa	GERRIT KEMME Zeeland	D. C. BLOEMENDAL Zeeland	2nd Tuesday Noon	2nd Tuesday December
Saginaw	W. K. ANDERSON Saginaw	H. C. WALLACE Saginaw	3rd Tuesday 8:30 p. m.	3rd Tuesday December
Schoolcraft	A. R. TUCKER Manistique	GEO. A. SHAW Manistique	On call	January 10
Shiawassee	W. E. WARD Owosso	R. J. BROWN Owosso	3rd Thursday Noon	3rd Thursday December
St. Clair	C. A. MacPHERSON St. Clair	JACOB H. BURLEY Port Huron	1st and 3rd Tuesdays Oct. to June	3rd Tuesday December
St. Joseph	R. A. SPRINGER Centreville	JOHN W. RICE Sturgis	1st Thursday 6:30 p. m.	1st Thursday January
Tuscola	LLOYD L. SAVAGE Caro	R. R. HOWLETT Caro	2nd Thursday 8:00 p. m.	2nd Thursday November
Washtenaw	S. L. LAFEVER Ann Arbor	WM. M. BRACE Ann Arbor	2nd Tuesday	2nd Tuesday December
Wayne	HENRY R. CARSTENS Detroit	B. I. JOHNSTONE Detroit	Every Monday 8:45 p. m. (Oct. to May. incl.)	3rd Monday in May
Wexford- Kalkaska- Missaukee	L. E. SHOWALTER Cadillac	B. A. HOLM Cadillac	Last Thursday	Last Thursday October

Among Our Contributors

Dr. George T. Aitken was graduated from the University of Indiana in 1933, interned at Harper Hospital, and then was resident in orthopedics at the Blodgett Memorial Hospital. Dr. Aitken was an instructor in anatomy at the University of Michigan Medical School for one year. Dr. Aitken has limited his practice to orthopedics, and is associated with Dr. John T. Hodgen of Grand Rapids.

* * *

Dr. Henry Cook is a graduate of the Detroit College of Medicine and Surgery. He has been a member of the Flint Board of Education twenty-four years and was the lay member of a commission appointed by the Governor in 1932 and 1933 to develop future plans for schools. He is president of the Michigan State Medical Society, 1937-1938.

* * *

Dr. **Barney A. Credille** was graduated from Tulane University, New Orleans, in 1918. He interned at the Ancon Hospital, Ancon Canal Zone, 1919-1920, and also at the Children's Hospital, Washington, D. C., and took up postgraduate work at the New York Post Graduate School. Dr. Credille is Chief of the Allergy Department, St. Joseph's Hospital, Flint, and his practice is limited to diseases of Allergy. He is a member of the American Society for the Study of Allergy.

* * *

Dr. Charles G. Johnston was graduated from Washington University School of Medicine. His specialty is general surgery and he is Professor of Surgery at the Wayne University College of Medicine and Director of Surgery in Receiving Hospital.

Hours: 9-5:30

HACK'S FOOT NOTES

Shoe Information for the Profession

RAndolph 7790

by the Hack Shoe Co., Inc. 5th Floor, Stroh Building

Vol. VIII Detroit, Michigan, July, 1938 No. 7

The Flexible Shank Fallacy is exploded by Dr. Adams,† "The midtarsal and tarsometarsal joints are not capable of any great excursion of motion . . .(they) . . . are simply shock absorbers." He states that in a flexible shanked shoe, "when this portion of the foot comes down under a load, it meets a surface which immediately drops away under it, for there is nothing for the midfoot to rest on."

A basic feature of Hack Shoes is the rigid shank.

†Adams, Z. B., Boston: "Shoeing." Med. Jour. & Record, (Jan. 21) 1925.

Foot Strain in Convalescence is described by John* as the precursor of much of the later foot troubles. He states, "Diminution in ligamentous and muscular support, especially in convalescence from illness, is a fourth cause of foot strain."

When the patient starts to bear weight, the proper foot support supplied by correctly fitting shoes can be of inestimable value in avoiding the foot strain which may otherwise date from the illness or operation.

*John, Rutherford L., Philadelphia: Surg. Clinics N. A., 15:2, 263-274, (Feb.) 1935.

INDEX TO ADVERTISERS

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All communications relative to exchanges, books for review, manuscripts, should be addressed to J. H. Dempster, M.D., 5761 Stanton Avenue, Detroit, Michigan.

All communications regarding advertising and subscriptions should be addressed to William J. Burns, LL.B., Executive Secretary, 2642 University Avenue, St. Paul, Minnesota, or 2020 Olds Tower, Lansing, Michigan. Telephone 5-7125.

Notice to Contributors

Owing to the limitation of space, preference will be given brief articles.

Manuscripts should be typewritten, double spaced, on one side of white paper 8½x11 inches. There should be a margin of 1½ inches on the left side of page. Do not send carbon copies; always submit the original typescript.

All photographs as illustrations should be clearly focused prints on glossy paper (do *not* send negatives). The standard 8x10 or 5x7 size prints are recommended.

All line drawings (charts, diagrams and sketches) are to be drawn with India ink on stiff white paper or Bristol board. Drawings are to be made with pen lines of suitable thickness to allow reduction to the width of one or two columns, as the case may be, of The Journal. Do *not* send drawings in colored ink.

Illustrations will not be accepted unless they reach a certain standard of excellence technically and present an attractive appearance. Illustrations, both photographs and drawings, are to be separate from the text. Each should be labeled on the back with the figure number, legend, title of paper and the author's name.

Reprints of papers published will be furnished authors if the order is placed at the time the galley proofs are returned to the editor. ***The cost of illustrations is to be defrayed by the author of the paper.***

Contributors are responsible for all statements, conclusions and methods in presenting their subjects. Their views may or may not be in agreement with those of the editor. The aim, however, is to allow authors as great latitude as the general policy of The Journal and the demands on its space may permit. The right to reduce in length, to alter by editing, or to reject any article is reserved. Articles are accepted for publication on condition that they are contributed solely to this Journal.